Health Care Financing Issues

HMOs: Issues and Alternatives for Medicare and Medicaid

Published by the Health Care Financing Administration
Office of Research, Demonstrations, and Statistics

Health Care Financing Issues

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HMOs: Issues and Alternatives for Medicare and Medicaid

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Published by
Department of Health and Human Services
Health Care Financing Administration
Office of Research, Demonstrations,
and Statistics

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Executive Summary

The Health Maintenance Organization (HMO) Act of 1973 was aimed at making HMOs a viable alternative to fee-for-service care by mandating that, where feasible, employers of 25 or more individuals offer a choice between their traditional health insurance packages and at least one HMO. In recent years, much study has been devoted to understanding the impact of HMOs on utilization, cost, quality of care, and competition in the health care marketplace. Much of this research predates the HMO Act and focuses on under-65 employed persons enrolled in prepaid group practices under group contracts.

Although Congress and the Department of Health and Human Services (DHHS) have generally supported the enrollment of Federal beneficiaries in HMOs, no more than 2 to 3 percent of these beneficiaries are HMO members. However, policymakers are becoming increasingly aware of HMOs' potential to contain health care costs without compromising quality of care. As means are sought to stimulate competition in the health care sector, HMOs are likely to become an important factor in whatever competitive approach is adopted. Consequently, there is renewed interest in promoting the expansion of Federal HMO contracting and Medicare and Medicaid enrollment.

This paper provides a comprehensive overview of the major issues and alternatives which need to be addressed if public payer participation in HMOs is to expand. It focuses on current legislative barriers to HMO enrollment, knowledge about HMO benefits and liabilities, reimbursement problems and techniques, marketing strategies, quality assurance, administrative issues, and a future research agenda.

Briefly, the paper supports the following conclusions with regard to HMOs and the Medicare program:

- Medicare beneficiaries will enroll in HMOs if benefit packages are attractive. Over 20,000 beneficiaries have enrolled at only three demonstration sites. Almost all have enrolled through open enrollment rather than conversion. This represents 36 percent of all enrollees in HMOs from Medicare's 38 cost contracts.
- HMOs will contract with the Health Care Financing Administration (HCFA) to enroll Medicare beneficiaries more readily if current risk and cost reimbursement procedures are modified.
- Most HMOs should be able to provide a full benefit package at 95 percent of the adjusted average per capita cost.
- More flexibility in current HMO reporting requirements and elimination of certain Medicare coverage restrictions (for example, spell of illness and physician extender use) would encourage more HMOs to contract with the Medicare program.
- The open enrollment procedure needs to be assessed to determine if a health status adjustment is required for adjusted average per capita cost determination. The issue of whether HMOs favorably or adversely select Medicare enrollees remains a key question which is being addressed by HCFA's current demonstration projects.

The Medicaid demonstration projects discussed in this paper have yielded findings which should be valuable in encouraging State contracts with HMOs. These findings include the following:

- Alternatives to door-to-door marketing can be effective in generating sufficient enrollments at a reasonable cost for most HMOs that would contract with a State.
- States can implement ambulatory quality assurance systems which will provide the data necessary to monitor under-utilization.
- States can use actuarial rate-setting methodologies to set rates for all categories of Medicaid recipients.
- In a competitive marketplace, medically needy enrollees not otherwise eligible for Federal assistance will be willing to pay increased premiums to join the HMO of their choice; they will not necessarily select the lowest cost HMO available.

Introduction

On February 18, 1971, President Nixon issued a health message to Congress. In it, he advocated prepaid health care as a new approach to health services delivery in which the Federal government should be viewed as one of several partners. The message underlined that the nation's health investment had reached nearly 8 percent of the GNP and announced a goal of 1,700 HMOs with 40 million members by 1976. By June 1976, only 1 percent of that goal (17 HMOs) had been realized. As of July 1980, 112 HMOs had been qualified by DHHS. A 10 year growth strategy developed by the Office of Health Maintenance Organizations now projects 442 HMOs serving over 19.1 million members to be qualified by 1988.[1]

Clearly, the HMO program has not yet fulfilled the hopes of its progenitors, and yet, many today believe that prepayment for health care might still be the most rational approach to restructuring the nation's health care delivery system. HMOs provide comprehensive health care reimbursed on a fixed *per capita* basis rather than fee-for-service. As a result of this payment mechanism, and an emphasis on health rather than the provision of services, HMOs have demonstrated a number of advantages, such as:

- a proven ability to reduce hospital admissions
- the ability to provide accessible, comprehensive services and continuity of care
- reduced out-of-pocket payments for health care
- incentives to promote health maintenance and prevention as opposed to more expensive acute care
- simplified claims procedures for both providers and beneficiaries
- the ability to perform the above without a reduction in quality of care
- introduction of a competitive framework for the health care sector.

Despite these benefits, success in attracting HMOs to contract with Medicare and Medicaid and in enrolling Federal beneficiaries in HMOs has been poorer than HMO development and penetration in the private sector. Supporters of HMO involvement with Medicare and Medicaid populations have had to face some special obstacles, ranging from legislative barriers to capitation reimbursement by the Medicare program to rapid turnover by Medicaid enrollees due to loss of eligibility. Except for a few demonstrations initiated to improve enrollment of Federal beneficiaries, even today no HMO delivers services to Medicare beneficiaries under reimbursement arrangements modeled after traditional HMO management principles. However, the experience of these experiments in marketing to Medicare beneficiaries does strongly suggest that incentives such as increased benefits and reduced copayments are effective in attracting the over-65 population at large to enroll.

Unlike Medicare, Medicaid has not faced legislative obstacles to non-cost-based HMO reimbursement. In fact, just the opposite is true: current regulations prohibit Medicaid agencies from entering cost contracts with qualified HMOs. But the difficulties are considerable in designing incentives to enroll categorical Medicaid recipients who already bear no out-of-pocket costs for medical care. In addition, many HMOs are not anxious to contract with States or serve the poor.

This paper reviews the interaction of the Medicare and Medicaid programs with HMOs, with specific emphasis on what has been learned from research and demonstration projects. Since much of the HCFA research is recent, particularly the Medicare demonstrations, the report should be considered as a snapshot look at the current state of the art. Preliminary findings from the implementation phases of these demonstrations, although necessarily tentative, have significance for current policy issues.

The first section discusses the current legislative and reimbursement provisions for HMOs wishing to contract with HCFA to serve Medicare or Medicaid beneficiaries. The numbers of contracts and beneficiaries served are reviewed and the impediments to growth outlined.

The second section contains an overview of the current knowledge about private sector and Medicaid experience in HMOs, focusing on utilization and costs, prevention, quality of care, enrollment, satisfaction, and disenrollment. Because few articles have been published on Medicare and HMOs, each is reviewed.

Section three provides a comprehensive review of Medicare HMO reimbursement issues, with emphasis on experience during the design phase of HCFA's seven Medicare risk-sharing demonstration projects. After outlining Medicare's current reimbursement procedures, the section reviews the problems in setting prospective rates and discusses the various experimental methodologies. Special attention is paid to the adverse/favorable selection issue. It is this issue, perhaps more than any other, which has for the past several years influenced legislative support for Medicare participation in HMOs.

Section four focuses on marketing and again is heavily weighted with experience from the Medicare demonstration projects. It also reviews results from California's recent demonstration of alternative methods of enrolling Medicaid recipients and two other Medicaid demonstrations.

Section five examines issues of quality assurance for Federal beneficiaries in HMOs. After reviewing current procedures and the status of HMOs' relationships with Professional Standards Review Organizations (PSROs), the section describes the quality assurance demonstration and evaluation in California which ended in winter of 1981.

1. "National HMO Development Strategy, 1978-1988," USDHEW, OHMO, Rockville, Md.

The sixth section reviews the various administrative issues which arose during the design of the Medicare demonstrations. This experience should be useful in refining HCFA's systems and procedures for managing Medicare HMO contracts.

Finally, the authors recommend directions for future research on Federal beneficiary enrollment in HMOs.

The Legislation and the Programs

The HMO act of 1973 substantially increased the ability of HMOs to compete with traditional health insurers by requiring that all employers covered by the Fair Labor Standards Act of 1938 and employing 25 or more offer at least one "group" and one "independent practice association" HMO as an alternative to whatever other health insurance package it offers to employees.[2] The employer must cover up to what it would pay for a non-HMO health insurance subscriber. In order to benefit from this "dual choice" provision of the law, HMOs must seek and be granted Federal qualification. This means, among other things, that they must offer a minimum benefit package provided under a community rating, and they must have at least one 30-day period per year during which any individual can apply and be accepted for membership.

Although some believe that the requirements for Federal qualification are unduly restrictive, the belief that government has a special responsibility to protect Federal beneficiaries from unscrupulous health care providers has led to minimal flexibility with regard to reimbursement, benefit packages, and structural characteristics required for an HMO wishing to contract to serve Medicare and/or Medicaid beneficiaries. This view was reinforced in 1975, after the unethical behavior of some prepaid health plans (PHPs) with Medicaid contracts in California was revealed in Congressional hearings. While the HMO Amendments of 1976 eliminated some of the worst barriers to HMO qualification, they signaled a strong orientation toward Medicare and Medicaid contracts with qualified HMOs only. For States like California, which at one point had 53 contracts with PHPs to serve over 250,000 Medicaid recipients, at a cost of $84.6 million per year, this meant the demise of all but 13 contracts.

Initiatives to revitalize the HMO movement in 1977 under Secretary Joseph Califano and Under-Secretary Hale Champion alleviated some of the factors which had slowed the development of HMOs, including lax Departmental management, administrative backlog in qualifying new HMOs, and excessive delays in issuing regulations. The HMO Amendments of 1978, enacted in November, resulted in a three year extension of the HMO program authorizations, increased and expanded support for developing HMOs in the form of grants, contracts, and loan guarantees, and introduced an HMO management intern program. However, the provisions of the bill introduced by Senator Richard Schweiker in February 1978 to stimulate meaningful participation of the poor and elderly in HMOs were deleted.

Hale Champion declared in a June 1977 policy speech at the Group Health Association of America convention: "Secretary Califano doesn't think HMOs are demonstration projects. He thinks they are for real." They may be for real, but for Medicare and Medicaid in 1980, they remained a footnote.

Medicare and HMOs

Prior to the enactment of the 1972 Amendments to the Social Security Act, Medicare beneficiaries enrolled in HMOs could receive prepaid services covered only under Part B from Group Practice Prepayment Plans (GPPPs). GPPPs are reimbursed on the basis of their reasonable costs. In March 1970, the Administration proposal known as the "Part C" fixed price prepayment option was added by the House Ways and Means Committee to a marked up welfare reform bill. At the same time, HEW issued a press release which included the following statement:

> Our goal, the Secretary said, is that every elderly or poor person, covered by Medicare or Medicaid, be given the right to choose between receiving services under such a contract and receiving individual hospital and physician services in the traditional manner. We must promote diversity, choice, and health competition in American Medicine if we are to escape from the grip of spiralling costs.[3]

However, the proposal, as ultimately enacted in Section 1876 of the Social Security Act (Section 226 of P.L. 92-603), little resembled the House version (H.R. 1). Viewing the proposal as an invitation to HMOs to reap excessive savings from the Medicare trust funds, the Senate Finance Committee prevailed in retaining in the legislation the essential elements of cost reimbursement. Final regulations implementing Section 1876 were not published until late 1976.

Section 1876 provides for two methods of reimbursement to HMOs, both involving a single capitation rate for services covered under Parts A and B of Medicare. A mature HMO may enter into either a cost or a risk basis contract.[4] Cost contracts permit reimbursement only

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2. A "medical group" is composed of a closed panel of physicians who pool their income and share common facilities, support staff, and medical records. A fee-for-service group that wishes to qualify as a "medical group" must, as its principal professional activity and group responsibility, engage in the coordinated practice of the profession for an HMO. The HMO Amendments of 1976 define this to mean that at least 35 percent of the group's patients must be prepaid. An "independent practice association" is composed of an open panel of fee-for-service solo practitioners in a group which agrees to provide prepaid care to plan subscribers.

3. Press release, March 25, 1970.

4. A mature HMO is defined in 45 CFR 405.2001(b)(1) as one which enrolls at least 5,000 prepaid members, provides all Part A and B services available to non-members in the service area, and meets all applicable Federal qualifying requirements.
To enter into a risk contract, a mature HMO must enroll at least 25,000 prepaid members, if it serves an urban area, and at least 5,000 if it serves a non-urban area (45 CFR 2004(a)(1) and (a)(2). A developing HMO may enter into a cost contract only, and must demonstrate to the Secretary that it is committed to meeting all of the requirements for a mature HMO within three years after the effective date of its initial contract (45 CFR 405.2001(a)(2)).

for the reasonable costs of providing covered items or services to Medicare enrollees. Reimbursement under a risk contract is based on a comparison of the HMOs' reasonable incurred costs and the Adjusted Average Per Capita Cost (AAPCC). The AAPCC is the average cost of providing covered items and services under fee-for-service in the same area as the HMO for the same demographic composition of Medicare beneficiaries enrolled in the HMO. (See the section on reimbursement for a more detailed discussion.) Under risk reimbursement, the Medicare beneficiary is "locked-in" to the HMO so that s/he may only receive services approved by the HMO. An HMO providing services under a risk contract is financially liable for covered services and items furnished to its Medicare enrollees outside the HMO, even in the absence of the HMO's prior approval, where such services are emergency or urgently needed, or are Medicare covered and determined by the Secretary not to have been made reasonably available by the HMO to its Medicare enrollees.

As of July 1980, the Medicare program had 38 cost contracts and one risk contract signed with HMOs to serve approximately 61,500 enrollees (representing less than 1 percent of the total Medicare population). Clearly, the lack of HMO penetration into the over-65 population can be traced, in part, to the above reimbursement provisions. If an HMO chooses cost reimbursement, it can broaden its sources of revenue at the price of filling out Federal cost reports and complying with other requirements for Federal qualification. This grafting of cost reimbursement on to HMOs, however, forces an awkward compromise on the HMO geared to operate under a prospective budget. The HMO that chooses a risk contract also must fill out the cost reports and be Federally qualified. But in addition, it runs the risk of adverse selection, as well as the responsibility for absorbing losses resulting from its own inefficiencies.

In addition to the impediments to development of HMOs in current reimbursement policies, marketing the HMO to the Medicare beneficiary is a problem. From the HMO's perspective, it is costly because Medicare beneficiaries are not part of a group and are difficult to reach. From the beneficiary's perspective, there are disincentives to enroll, such as the "lock-in." HMO enrollment for the Medicare beneficiary also means incurring the same deductibles and coinsurance costs for no richer array of benefits than they are entitled to under Parts A and B of Medicare.

Medicaid and HMOs

The HMO was initially developed to deliver health care to employed persons and their families. As enacted in 1965, Title XIX did not provide for the enrollment of Medicaid eligibles in HMOs. The first efforts to enroll low income persons in HMOs were supported by the Office of Economic Opportunity (OEO). HMOs such as the Health Insurance Plan (HIP) of New York, Group Health Cooperative (GHC) of Puget Sound, and various Kaiser plans were awarded Neighborhood Health Center grant funds to enroll low income persons not necessarily eligible for Medicaid. The grant funds also provided services such as child care and social services not normally covered under Title XIX. Thus both the HMOs and low income populations had incentives to participate through guaranteed eligibility and enriched benefit packages.

The legislative authority for States to contract with HMOs is contained in Section 1902(a)(23) of the 1967 Amendments to the Social Security Act (Section 227(a)(3)). Known as the "freedom of choice" provision, it recognizes an "organization which provides services, or arranges for their availability on a prepayment basis." Regulations for implementing this legislation provided little guidance other than (1) that the State specify the amount of the premium, the services covered, and the term of the contract; (2) that the premium payment fully discharges the State from responsibility for the costs of the covered services; (3) that the premium amount and/or covered services be periodically renegotiated; and (4) that the State require the prepaid health plan to maintain and provide such records and reports necessary for the State to meet Federal reporting requirements. The State, in order to obtain Federal sharing, had to pay the plan premiums which would not exceed the cost of providing the same services under the fee-for-service system. Prior Departmental approval of HMO contracts was not required. The 1972 Amendments to the Act amended Section 1902(a)(23) to allow States to contract with an organization to provide care and services in addition to those under the State plan in a sub-state area, thereby avoiding conflict with the state-wide and comparability provisions of the law.

Twelve States, including the District of Columbia, signed 66 contracts with HMOs between 1971 and 1973 to serve a total enrolled population of about 371,000 Medicaid eligibles.[5] Fifty of these contracts were implemented in California under the Medi-Cal Reform Act of 1971. But within the first year of this program in California, serious complaints were raised about the cost, quality, enrollment practices, and corporate accountability of the PHPs contracting with the State. Failure by both the State and the Department to adequately address these complaints culminated in hearings in 1975 held by the Senate Permanent Subcommittee on Investigations of the Committee on Governmental Affairs. One of the chief charges directed at HEW in those hearings was that the Department had yet to issue regulations specifying the procedures for obtaining a determination of whether an HMO should be "qualified" under the HMO Act of 1973. The regulations were finally published on August 9, 1975, placing a number of new requirements on State contracts with HMOs. These included (1) that the State control HMO enrollment and disenrollment practices; (2) that services be available on a 24 hour, seven days a week emergency basis; (3) that internal grievance procedures be established; and (4) that a medical record-keeping system exist. The regulations

5. *State Medicaid HMO Contracts,* USDHEW, Social and Rehabilitation Service, Medical Services Administration (SRS-74-24807), September 1973.

also expanded access to records requirements by stipulating that the State and the Department have the right to inspect and evaluate the quality, appropriateness, and timeliness of services provided and audit and inspect any books and records of the HMO which relate to the contract. The State also had to provide HEW with the actuarial basis for the premium determination, and the Department required prior approval of contracts with expected values of $100,000 or more.

The HMO Amendments of 1976 went further toward correcting the conditions which permitted the scandals in California to occur. Title XIX matching funds were limited to Federally qualified HMOs with few exceptions, and qualified HMOs were restricted from enrolling more than 50 percent of their members from Medicare and Medicaid. Although the 50 percent requirement may ensure quality service provision for Federal beneficiaries, it also establishes a new access barrier to HMOs for beneficiaries residing in inner city areas.

As of 1980, 53 HMOs in 17 States had contracts to serve Medicaid recipients.[6] Twelve of these contracts are in California, seven in Maryland, five in Michigan, and four each in Massachusetts, New York, and Minnesota. Approximately 270,000 Medicaid recipients are enrolled in HMOs, representing about 2 percent of total eligibles and 6.7 percent of the total enrollment of the plans. Although contracts with qualified HMOs increased from 24 to 27 between 1978 and 1980, Medicaid enrollment has dropped nearly 15 percent. A strong potential for further reductions in enrollments exists due to the large number of current contracts with non-qualified plans. Only 55 percent of current contracts are with qualified HMOs; the 1976 amendments permit States to contract with non-qualified HMOs under limited defined circumstances or for a three year period when the plan is seeking Federal qualification. Should many of the 24 non-qualified contracting plans not receive qualification, their contracts would be terminated.

Current Knowledge

Private Sector Research

The paucity of Medicare and Medicaid beneficiaries enrolled in HMOs has yielded a commensurate dearth of research on cost, utilization, marketing, and quality of care delivered to the poor and elderly in HMOs. To date, most of the research on HMO performance has been based on private sector data, particularly from a small number of HMOs which have consistently participated in research studies. This research has produced some generally accepted conclusions about HMOs, as well as some clear indications about where more study is needed. The following section consists of a brief review of the state of the art, focusing on those aspects of research which are relevant to Medicare and Medicaid involvement in HMOs.

6. Most of the statistics quoted here were prepared by HCFA's Division of Alternative Reimbursement Systems in a report entitled "Medicaid Experience Summary with HMOs and Other Prepayment Plans."

Utilization and Costs

From his exhaustive assessment of the available literature on HMOs, Harold Luft concluded that members of staff model HMOs/prepaid group practices (PGPs) have the lowest costs, as compared to members of independent practice associations (IPAs) and major medical-indemnity plans.[7] Luft determined that annual costs for Blue Cross/Blue Shield subscribers were 16 to 88 percent higher than for enrollees in the lowest cost PGPs. In addition, average out-of-pocket costs per person and per family for HMO enrollees were less, particularly in staff as opposed to IPA models. We do not know, however, whether these cost differences represent true cost savings because of the self-selection factor. That is, those who choose to enroll in an HMO may be different from the general population on one or more parameters which have a proven correlation to the use of health care. HMO enrollees may be healthier, or they may seek less health care, regardless of their health conditions.

The chief means by which HMOs control costs is reduced hospitalization. Luft found that in 44 of the 57 comparisons of HMO to fee-for-service experience, dating back to 1951, HMO enrollees had fewer hospital days than the comparison group. In 46 cases, the admission rate was lower. HMOs do not appear to have a significant effect on length of stay (LOS). Out of the 57 cases, 30 showed lower LOS, six were the same, and 21 were higher. Case-mix adjustments do not alter this finding. Overall, the utilization of staff model HMOs is about 35 percent less than comparison groups, while IPAs are about 5 to 25 percent lower. As to whether these results are associated with self-selection, the evidence is mixed. Some studies indicate that those likely to be high users tend to opt for conventional health insurance plans. On the other hand, some argue that persons who anticipate a high need for health care are more likely to choose an HMO.

Studies about the relationships of HMOs and ambulatory care are less conclusive than those about hospitalization. The HMO rhetoric frequently refers to the substitution of less expensive outpatient care. But more study is needed to understand the dynamics of this: Do HMOs eliminate unnecessary care, do they underserve, do they selectively enroll, or do they substitute ambulatory care? The only sure conclusion which Luft could draw from his analysis was that a larger proportion of HMO enrollees have at least one visit per year compared to non-enrollees. He also was reasonably confident that, while HMO enrollees have more ambulatory visits per year than people in comparison groups, the difference is less than 10 percent, and nearly as many HMOs show fewer visits per year as show more. The actual extent of substitution of physician visits and ancillary services for inpatient care is not known.

7. Luft, H. S., *Health Maintenance Organizations: Dimensions of Performance* (A Wiley-Interscience Publication: John Wiley & Sons, New York), in publication.

Prevention

One of the chief benefits that HMOs claim is that they respond to incentives to provide preventive care because in doing so they save the costs they would have otherwise incurred for acute care. But studies comparing the use of preventive services by HMO enrollees and non-enrollees produce conflicting results. Contrary to popular expectation, non-enrollees used preventive care more or as much as HMO enrollees in four out of 11 studies analyzed by Luft. The explanation appears to be that demand for preventive services is more a function of coverage than provider philosophy.

Analysis of preventive care is beset by some thorny problems, such as defining preventive care and understanding the role of the physician in his or her choices of services. Furthermore, intuitive assumptions that preventive care is always good are subject to challenge in terms of efficacy as well as economic costs and benefits. However, two perspectives are available from which to consider the provision of preventive services in HMOs. From the HMO's perspective, there are clear economic incentives to discourage the unnecessary provision of discretionary, preventive services; from the enrollee's perspective, the elimination or reduction of out-of-pocket costs for ambulatory care appears to act as an incentive to seek preventive services. The value and appeal of preventive care to the elderly has received little, if any, research attention to date. Assuming prevention is valuable, we have very little information about current utilization of such services by Medicare beneficiaries or how more comprehensive coverage would affect utilization.

Quality

Two comprehensive reviews of the literature on quality of care delivered by HMOs have been performed.[8] [9] Both recognize that the state of the art limits the certainty of conclusions, and both exonerate HMOs in general from the allegation that they underserve enrollees to achieve economies.

The first review, by Luft, is organized on the basis of structure, process, and outcome studies. With regard to structure, Luft concludes that HMOs are at least as good as fee-for-service: HMOs seem more likely to recruit and attract more certified specialists (although the superiority of such credentials is unproven), admit to accredited hospitals, and provide more continuing education to their staff. On the other hand, arguments that physicians in HMOs more frequently consult with each other was not supported by Luft's review. Luft also found that while internal peer review is present in most HMOs, it is not found in all of them. Where information on quality is available, it is not clear whether it is used or is effective in instituting improvements.

The relationship of the process of care to quality is nearly as tenuous as the relationship of structure to quality. Luft makes the point that assessments of quality delivered in HMOs based on process measures are easily biased in favor of settings which keep good records and offer an array of technical services. Thus, HMOs appear to do better on process measures which pick up lab tests and procedures, but this could be more due to coverage than quality differences. Studies based on HMO outcomes are quite few and of limited value due to small sample sizes. However, the preponderance of what is available suggests that HMO outcomes are not significantly different than fee-for-service.

The conclusions of the second review, by Frances C. Cunningham and John W. Williamson, are more positive than Luft's. The authors analyzed 25 studies in which they identified 34 different measures of quality (seven outcome, 25 process, and two structure). The studies reported a total of 84 quality measurements, of which 65 were considered valid for this review. Of the 65 measures, care provided by HMOs appeared superior in 50 cases, similar in 14, and inferior in one (a Medicaid population). The authors concluded that the quality of care provided by HMOs is comparable, if not superior, to conventional settings.

Enrollment, Satisfaction, and Disenrollment

The literature on satisfaction reviewed by Luft indicates that HMO enrollees are more satisfied with their financial coverage than non-enrollees. Thus, while a person who chooses HMO enrollment because of its better financial coverage may subsequently disenroll because of dissatisfaction with something else, financial coverage remains a key means to motivate enrollment. The significance of this for Medicare and Medicaid is that these programs can do little within their current authority to motivate enrollment via financial incentives.

Aside from economic incentives, studies about why people choose HMOs focus on their feelings about the care they receive, out-of-plan utilization, and disenrollment. Luft calls the latter two "behavioral correlates of satisfaction." Overall, Luft found that out-of-plan utilization accounts for 7 to 14 percent of all services received by HMO enrollees. Outside users are the ones who most frequently express dissatisfaction in surveys. The percentage of those who disenroll annually is usually under 10 percent. Curiously, some plans with the lowest disenrollment rates do more poorly in measures of consumer satisfaction than plans with less stable enrollment. Hirschman has shown that HMO enrollees are generally more informed consumers, and as such, they may be more vocal in their complaints.[10] Nevertheless, even the complainers usually do not disenroll, probably because they enjoy the coverage they receive at a reasonable premium.

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8. See Footnote 7.

9. Cunningham, F. C. and J. W. Williamson, "How Does the Quality of Health Care in HMOs Compare to That in Other Settings? An Analytic Literature Review: 1955 to 1979." *The Group Health Journal,* Winter 1980, pp. 4-13.

10. Hirshman, A. O., *Exit, Voice and Loyalty: Responses to Decline in Firms, Organizations, and States,* (Cambridge: Harvard University Press), 1970.

Since the Medicaid and Medicare programs cannot offer financial savings to encourage beneficiaries to join HMOs, it is important to consider what other factors might motivate enrollment. These factors might include certain benefits which HMO members presumably enjoy, such as better accessibility. Luft found that while HMOs offer shorter office waiting times, waiting times for appointments are longer. For elderly people with urgent needs who visit the doctor frequently, this could be a significant deterrent to HMO membership. For the low income person, this may be less important than simply having a health provider in the vicinity who accepts Medicaid patients.

Continuity of care is often assumed to be more readily available to HMO members. The empirical benefits of continuity of care are by no means clearly defined; however, there is some consensus that continuity is a necessary component of quality. Without the availability of a longitudinal medical record and/or a physician who knows the patient, it is presumed that effective prevention, identification, and treatment of disease cannot be achieved. It appears that HMOs provide less opportunity for members to identify with a personal physician but possibly better maintenance of medical records.[11] Self-selection may partially account for this if HMOs automatically attract people who have and seek no personal physician relationship. By the same token, however, many elderly persons highly value this relationship. Unless the HMO offers an appealing substitute to their current doctor, they may not enroll. Furthermore, since the evidence shows that HMO enrollees are less satisfied with doctor-patient communication and relationships, disenrollment among the elderly may prove higher.

Summary

With minimal equivocation, researchers attribute HMOs' lesser costs to reductions in hospitalization. To what reduced hospitalization should be attributed, however, is part of an important controversy about self-selection which is discussed elsewhere in this report. The effect of HMOs on the use of ambulatory and preventive care has less consensus than HMOs' effect on inpatient use, due in part to the wide variety of services encompassed by ambulatory preventive care. One can find studies which argue that HMOs provide more or less of such services. But the theory that HMOs provide more to prevent future illness is treated with increasing skepticism. To the extent that quality of care lends itself to measurement, no consistent evidence of lesser quality in HMOs has yet been produced, while there is some research suggesting that HMOs may offer improved quality over fee-for-service medicine. Studies about consumer attitudes on health insurance show that HMO enrollment affords more satisfaction with financial coverage than do fee-for-service plans. Other factors which may play a role in HMOs attracting and retaining members are accessibility and continuity of care.

11. Richardson, W. C., S. M. Shortell, P. K. Diehr, "Access to Care and Patient Satisfaction," in William C. Richardson, (editor), *The Seattle Prepaid Health Care Project: Comparison of Health Services Delivery,* Seattle: University of Washington, School of Public Health and Community Medicine, 1976.

Research on Medicaid, Medicare, and HMOs

Medicaid

Medicaid and related programs have had a broader experience with prepaid contracting than the Medicare program. This has resulted in three types of studies on the subject: (1) studies which deal with low income (such as Office of Economic Opportunity (OEO)) populations not necessarily on public assistance, (2) studies concerned with Medicaid eligibles, and (3) analyses of the California Medi-Cal experience. For a complete review of the literature about Medicaid as well as low income persons in HMOs, Margo L. Vignola and George B. Strumpf have prepared an annotated bibliography entitled: *Medicaid Eligibles in Health Maintenance Organizations: Utilization, Cost, Quality, Legal Requirements* (December 1977, updated in 1980). Below is a brief overview of the major issues regarding Medicaid and HMOs.

UTILIZATION AND COSTS

Since the inception of Medicaid, a benchmark of the program's success has been how well it has brought the poor into the mainstream of health care. This goal assumes that patient needs are similar, regardless of socio-economic status. While a number of studies compare OEO and other low income populations' utilization of HMOs to middle class enrollees in the same HMO, only one such study is based on Medicaid recipients.[12] This study compared the utilization experience of Medicaid and non-Medicaid low income enrollees in the Harvard Community Health Plan (HCHP) to employer group enrollees. The researchers found that Medicaid enrollees cost less and used fewer hospital days per 1,000 than group enrollees (234.5 versus 286.4), while low income days per 1,000 were significantly higher (462.1) than days for Medicaid or group enrollees. Medicaid and group utilization and costs for ambulatory care were comparable, but low income populations' ambulatory utilization, again, was higher, with the exception of adult females.

There are two well-known studies which compare Medicaid enrollee utilization in HMOs to Medicaid fee-for-service. One is based on the experience of Group Health Association (GHA) in Washington, D.C., and the other on an analysis of 10 HMOs (six in California, Group Health Cooperative of Puget Sound in Washington, HCHP in Massachusetts, HIP of Greater New York, and the Temple Health Plan of Pennsylvania).[13] [14]

12. Coltin, C. C., R. Neisuler, and R. S. Luria, *Evaluation of a Program to Facilitate the Integration of a Low Income Population Into a Prepaid Group Practice,* (Harvard Community Health Plan: Cambridge, July 1976).

13. (1) Fuller, N. and M. Patera, *Report on a Study of Medicaid Utilization in a Prepaid Group Practice Plan,* (DHEW/PHS/MSA) Washington, D.C., January 1976; and (2) Fuller, N., M. Patera, and K. Koziol, "Medicaid Utilization of Services in a Prepaid Group Practice Health Plan," *Medical Care,* September 1977, pp. 705-737.

14. Gaus, C., B. Cooper, and C. Hirschman, "Contrasts in HMO and Fee-For-Service Performance," *Social Security Bulletin,* May 1976, pp. 3-14.

The GHA study is based on 1,000 Medicaid recipients enrolled between 1972 and 1974 and a control group composed of the AFDC and disabled Medicaid universe in Washington, D.C. for fiscal year 1972. It excluded individuals under age 1 and over age 65. Both inpatient and ambulatory utilization were lower after enrollment and lower than that of the control group. Despite inclusion of four additional benefits (dental, outreach, prosthetic, and ambulance), the costs per enrollee did not increase over three years and actually decreased between 1972 and 1973. This contrasts with a control group annual cost increase per person from $373 in 1972 to $465 in 1974.

Unlike some HMO studies, the GHA study did look at the incidence of out-of-plan utilization. Claims that HMOs reduce utilization and costs cannot be fully substantiated without knowing the extent to which enrollees have used out-of-plan services, whether they were paid for, and by what party. The GHA study found out-of-plan use to be quite low, although there were significant out-of-plan purchases of prescription drugs. Barring abuses, these services were paid for out-of-pocket; Medicaid recipients who joined GHA surrendered their Medicaid cards.

The other widely known study about Medicaid utilization in HMOs compared the experience of 8,000 Medicaid families in 10 HMOs to fee-for-service utilization. Using a matched control group, the study found that hospital utilization and the incidence of surgery were less than fee-for-service for prepaid group practices but that there were no significant differences in utilization between foundations for medical care (that is, IPAs) and fee-for-service. The authors concluded that organized groups of salaried physicians may exert more influence on utilization than capitation payments alone. This study did not assess cost differences. In ambulatory care, the study showed no differences between HMO and fee-for-service controls. The authors posited this, as did the GHA study, as evidence that reductions in hospitalization are not achieved by substituting ambulatory care.

This study also reported minimal out-of-plan usage—less than 1 percent. Other research is showing that a significant proportion of Medicaid enrollees do use out-of-plan services. A study of 1972 utilization data for HIP Medicaid enrollees showed that the Medicaid enrollees were seeking one-half to two-thirds fewer physician visits than regular HIP subscribers.[15] However, after analyzing a sample of claims submitted by fee-for-service providers to see how many services they delivered to HIP Medicaid enrollees, it turned out that two-thirds of the physician services the enrollees were receiving were delivered out-of-plan. The study did not report how many of these claims were actually paid by the State. Further, since the HIP contract did not include all of the services covered by the State, not all of the out-of-plan utilization was inappropriate.

15. Hester, J. and E. Sussman, "Medicaid Prepayment: Concept and Implementation," *Milbank Memorial Fund Quarterly/Health and Society,* Fall 1974, pp. 415-444.

A recently completed analysis of out-of-plan utilization by 425 AFDC recipients enrolled in "a large HMO in Massachusetts" between April 1977 and June 1978, however, suggests that HIP's experience may not be unique.[16] Thirty-eight percent of the AFDC enrollees in this HMO used non-emergency, non-urgent, out-of-plan ambulatory services during a one year period, with women more likely to do so than their children. The length of pre-enrollment eligibility was unrelated to out-of-plan utilization during enrollment. In addition, the types and patterns of use of out-of-plan providers were similar before and after enrollment. However, high users of ambulatory care before enrollment did appear more likely to use out-of-plan services after enrollment than low users before enrollment. The authors suggest that HMO marketing and enrollment of Medicaid recipients who have established relationships with fee-for-service providers may not be appropriate and that better education of enrollees on proper use of the HMO may be helpful.

QUALITY OF CARE

With quality of care measurement at its present level of sophistication, the extent of preventive care provided is frequently used as a proxy for quality. Studies which compare the use of preventive services between Medicaid and fee-for-service populations produce contradictory results. Analyses of the East Baltimore Medical Plan indicate that higher proportions of enrolled children receive some preventive care than children treated by fee-for-service doctors and that enrolled children are more likely to receive care.[17] [18] In the GHA study, in which Luft identified seven types of preventive services, use of these services was significantly higher for the enrolled group; however, the proportion of children under six who had ever received each of five immunizations and the percentages of women who received pre- and post-natal care were consistently lower for the enrolled populations.

Measures of maternity care used in the study comparing 10 HMOs to fee-for-service care also showed that 52 percent of enrolled women with live births had 11 or more prenatal visits compared to 60 percent in the controls.[19] The authors concluded that HMOs do not provide more preventive care than fee-for-service care; at no site was preventive care greater in HMOs, and in some it was significantly less.

16. Nassif, D., S. Smith, D. Sisson, and C. Greenfield, "Out of Plan Utilization by Medicaid Recipients Enrolled in an HMO Program," presented at the 108th APHA Annual Meeting, October 1980.

17. German, P., E. Skinner, S. Shapiro, and D. Salkever, "Preventive and Episodic Health Care of Inner-City Children," *Journal of Community Health,* pp. 92-106, 1976.

18. Salkever, D. S., P. S. German, S. Shapiro, R. Morky, and E. A. Skinner, "Episodes of Illness and Access to Care in the Inner City: A Comparison of HMO and non-HMO Populations," *Health Services Research* 11, pp. 252-270, 1976.

19. See Footnote 14.

In addition to looking at preventive services, some studies attempt to draw conclusions about quality from mortality and utilization statistics. In 1967, Shapiro found that the proportion of indigent aged persons who received no physician services after enrolling in HIP in 1962 went down compared to no change in the non-HIP group.[20] But previous high users of care who enrolled averaged fewer physician visits in HIP than under fee-for-service. The death rate for ambulatory enrollees in the 18 months following the study year was 14 percent lower than the comparison group.

Another way of addressing quality of care is to determine whether services are accessible in the first place. Since a major HMO selling point for Medicaid recipients is accessibility to providers who will always treat them, it is particularly important to know if HMOs are adequately delivering "accessibility." Although there are no studies on whether the same HMO is as accessible to its Medicaid enrollees as it is to its employed groups, there are a number of studies which compare the accessibility of care to Medicaid enrollees and fee-for-service Medicaid control groups. Waiting time in HMO offices is uniformly shorter than for fee-for-service doctors, but in some cases, it takes longer to get an appointment. Other measures of accessibility with conflicting results include telephone access, general convenience, time allocated with physician for appointment, and physical access.

LoGerfo *et al* conducted a study under the Seattle Prepaid Health Project which concerned low income as opposed to categorically needy persons. The study found consistently higher compliance with optimal care criteria for urinary tract infections for enrollees in the Group Health Cooperative of Puget Sound compared to those receiving care from physician members of King County Medical/Blue Shield county-wide medical services.[21] Furthermore, higher surgical rates for four common procedures in the fee-for-service group were, in part, attributable to a higher proportion of cases which did not meet "common criteria" for surgery.[22]

On the neutral side, the study of 10 HMOs showed that HMO enrollees averaged 1.3 days of disability per month compared to controls which averaged 1.4 days, although the authors concede that no direct attempt was made to measure health status.[23] Another study with inconclusive results was conducted by Louis and McCord.[24] The study was undertaken amid the uproar in the mid-1970s concerning the entire management of the PHP program in California. The authors found the PHPs to be structurally adequate in most respects except peer review. They evaluated process of care to determine if basic health assessment and maintenance services were being provided and observed substantial variations between PHPs. Fee-for-service providers scored higher on quality of infant care, while the PHPs did better for school-aged children and adults. Analyses of disease specific processes again showed wide variations between PHPs, some better, some worse than fee-for-service care. The authors most pointed conclusion was that the quality of care provided to Medi-Cal recipients was disappointingly low, regardless of whether it was fee-for-service or PHP.

ENROLLMENT, SATISFACTION, AND DISENROLLMENT

Marketing HMOs to Medicaid recipients is difficult due to a number of factors. Many recipients simply are not aware that they have a choice. If they are, choice may seem unimportant because of the more immediate non-health related problems that welfare applicants must cope with. Even if the choice is perceived as important, adequate information on specific HMOs—their location, their hours of operation, etc.—may not be readily available. Furthermore, since Medicaid eligibility is not assured for a fixed length of time, the HMOs may not elect to market aggressively.

If the Medicaid program is ever to enroll recipients in substantial numbers in HMOs, policymakers need a better understanding of the key factors which motivate this choice. In Thomas Bice's study of the East Baltimore Medical Plan (EBMP), dissatisfaction with fee-for-service care was related to Medicaid recipients' decision to enroll.[25] At the same time, expressions of dissatisfaction with fee-for-service by enrollees were not intense. There are at least two possible explanations for this anomaly. First, the Medicaid population may be quite similar to other groups surveyed about satisfaction with their current sources of care: people rarely admit serious fault with their doctors.[26] Or Medicaid recipients may have low expectations about the kind of

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20. Shapiro, S., J. J. Williams, S. Jerley, P. M. Densen, and H. Rosner, "Patterns of Medical Care by the Indigent Aged Under Two Systems of Medical Care," *American Journal of Public Health* 57, pp. 784-790, 1967.

21. LoGerfo, J. P., J. Larson, and W. C. Richardson, "Assessing the Quality of Care for Urinary Tract Infection in Office Practice: A Comparative Organizational Study," *Medical Care* 16, pp. 488-495, 1978.

22. LoGerfo, J. P., R. A. Efird, P. K. Diehr, and W. C. Richardson, "Rates of Surgical Care in Prepaid Group Practices and the Independent Setting: What are the Reasons for the Differences?" *Medical Care* 17, pp. 1-7, 1979.

23. See Footnote 14.

24. Louis, D. Z. and J. J. McCord, *Evaluation of California's Prepaid Health Plans (PHPs): Final Report,* Contract No. HEW-OS-73-194. Santa Barbara, California: General Research Corporation, 1974.

25. Bice, T. W., *Enrollment in a Prepaid Group Practice* (Baltimore: The Johns Hopkins University), 1973.

26. Lebow, J. L., "Consumer Assessments of Quality of Medical Care," *Medical Care,* 12:4 (April 1974), 328-337.

medical care available to them.[27] Their satisfaction may more appropriately be termed resignation. Bice's research at EBMP also suggests that, for Medicaid recipients, poor health status is not a good predictor of enrollment. At the same time, those who will have less out-of-pocket costs by joining an HMO (that is, non-Medicaid persons) are more likely to join. It is not unreasonable to assume then, for non-Medicaid persons, that some percentage of them will opt for an HMO if they anticipate lower health status and consequently more health expenditures.[28] While one cannot dismiss the potential for an adverse selection of Medicaid enrollees, the fact that the HMO cannot usually offer reduced out-of-pocket costs to Medicaid enrollees should dispel some of this concern.

One of the least expensive, more effective ways for an HMO to attract members is through word-of-mouth. Thus, in addition to discovering what advantages of HMOs should be emphasized to encourage enrollment, policymakers and HMOs might also benefit from identifying those characteristics of various plans which appeal to or alienate their Medicaid members. The elements of GHA that enrollees liked the most were convenience, personalized service by nurses, the dental program, and quality of care.[29] They reported the most dissatisfaction regarding doctors, who were described as failing to explain facts and treat them with respect.

Voluntary disenrollment, of course, is often the expression of ultimate dissatisfaction. In the GHA study, only 2.5 percent voluntarily disenrolled over the 32 months of the project. (Eligibility was guaranteed for the entire period.) In the EBMP, 25 percent voluntarily disenrolled over the 23 month life of the project.[30] Disenrollment was disproportionately high in the early months of the project and the disenrollees had a much higher proportion of out-of-plan utilization during enrollment. About 6.5 percent of the low income enrollees in Group Health Cooperative under the Seattle Model Cities Project left the plan each year. Overall, a certain percentage of HMO members, usually less than 10 percent, will exit by choice from the plan each year. Medicaid voluntary disenrollment rates are probably not different, in general, than the voluntary exit rates of employed persons from HMOs.

27. Owen, E. W., "Proposal to Demonstrate Marketing—Enrollment and Grievance—Disenrollment Systems," Prepaid Health Research, Evaluation and Demonstration Project, California Department of Health Services, December 1977.

28. Bice, T. W., "Risk Vulnerability and Enrollment in a Prepaid Group Practice," *Medical Care* 13:8 (August 1975) pp. 698-703.

29. See Footnote 13.

30. Wollstadt, L. J., S. Shapiro, and T. W. Bice, "Disenrollment from a Prepaid Group Practice: An Actuarial and Demographic Description," *Inquiry* 15:2 (June 1978), pp. 142-150.

A DIGRESSION ABOUT CALIFORNIA

It is impossible to leave the subject of Medicaid and HMOs without addressing the California experience. What happened in California between 1971 and 1975, and the publicity which accompanied it, intimidated many other States, Congress, and the Department into adopting an extremely cautious approach to the development of Medicaid contracts with prepaid health plans as well as HMOs.

In 1971, California initiated major reforms in its Medi-Cal program, chiefly aimed at controlling runaway costs which had risen from $507 million to $1 billion between 1967 and 1970. One of the main provisions of the Medi-Cal Reform Act of 1971 was the authorization of minimal restraints on State contracting with PHPs, while placing new restrictions on fee-for-service utilization (that is, prior authorization for use of certain services and copayment requirements). PHPs sprung up in California overnight, many of them enrolling only Medi-Cal recipients. By 1974, 10 percent of the Medi-Cal population was receiving services on a prepaid basis.

Within the first year of the PHP program in California, interested and affected constituencies began to complain about the cost, quality, enrollment practices, and corporate accountability of the PHPs which were contracting with the State. In response, the State enacted the Waxman-Duffy Prepaid Health Plan Act of 1973, which established some standards of marketing, placed a ceiling on the proportion of Medi-Cal enrollees, and provided for public hearings on PHP contract renewals. Unfortunately, the Waxman-Duffy legislation had little impact because the State never effectively enforced the law. Scathing articles began to appear in newspapers, particularly in Los Angeles. The General Accounting Office issued a report which focused on the unusually high capitation payments being made to some PHP contractors.[31] Neighborhood groups, consumer organizations, welfare workers, public health nurses, legal aid societies, local health departments, medical associations, and comprehensive health planning councils continued to register ever-louder complaints. This pressure culminated in hearings on March 13 and 14, 1975, before Senator Henry Jackson's Subcommittee on Investigations of the Committee on Government Operations.[32] During the hearings, sworn testimony was heard documenting widespread abuse in the State-contracted PHPs:

31. "Better Controls Needed for Health Maintenance Organizations Under Medicaid in California," General Accounting Office, September 1974.

32. U.S. Senate, Committee on Government Operations, Permanent Subcommittee on Investigations: Hearings on Prepaid Health Plans, March 13-14, 1975, 94th Congress, U.S. Government Printing Office, Washington, D.C., 1975.

(1) quality of care—care unavailable, patients sent to county hospitals at expense of county, unqualified doctors, refusal to perform necessary operations, inferior hospitals providing hospital care to PHPs
(2) fraudulent marketing, enrollment, and disenrollment practices—deceptive marketing (door-to-door enrollers in white coats, telling recipients that they would lose their Medi-Cal cards if they did not enroll), enrolling derelicts and drug addicts merely to get names, forged enrollments, involuntary disenrollment when enrollees needed expensive care
(3) complicated networks of for-profit subsidiaries of "non-profit" PHPs
(4) use by PHPs of poor quality, for-profit hospitals—The Joint Commission on Accreditation of Hospitals came under heavy attack for relying solely on physical facilities without the expertise to evaluate physician qualifications and quality of care.

In addition to documenting the above, the Subcommittee received sworn affadavits pointing to specific examples where the State Department of Health Services had quashed investigations, removed overly insistent investigators, lost complaint files, failed to adequately investigate the backgrounds of applicants for contracts, and failed to develop adequate guidelines for medical auditors.

Response at all levels to the California PHP scandal has virtually ensured that the situation will not recur. The hearings held in March 1975 and again on December 14 and 15[33] resulted in the following initiatives:

- The 1976 Amendments to the HMO Act require all Medicaid contractors to meet the requirements of Title XIII for qualified HMOs, with few exceptions.
- DHHS awarded a $5.3 million grant (the Prepaid Health Research Evaluation and Demonstration Project) to California's Department of Health Services to develop model rate-setting, quality, and membership systems for use in California. The demonstrations and products of the PHRED project, which are transportable to other States, will be discussed in detail at various points throughout this report.
- The Senate enacted new legislation (AB 1963), which contains authority to abolish door-to-door marketing, mandates actuarial rate-setting, improves grievance and disenrollment procedures, and mandates accessibility to PHP data.

33. U.S. Senate, Committee of Government Operations, Permanent Subcommittee on Investigations: Hearings on Prepaid Health Plans, December 14 and 15, 1976. 94th Congress, U.S. Government Printing Office, Washington, D.C., 1977.

Medicare

The small number of studies on the Medicare experience with HMOs is striking. No study has been completed on the utilization of services by Medicare beneficiaries enrolled under cost contracts. All studies, with the sole exception of the recent Group Health Cooperative assessment, are based on pre-1973 experience. A summary of these studies follows:

- "Some Aspects of Medicare Experience with GPPPs," (Corbin and Krute, 1975): This study compares the utilization and reimbursement experience of seven GPPPs in New York, Michigan, California, and Washington in 1969 and 1970 for Medicare enrollees and fee-for-service controls. Total reimbursement per beneficiary was lower than controls for five of the seven plans. Payments for inpatient care were lower than controls in all plans, while reimbursement for physicians' services was consistently higher. In the two plans where lower inpatient costs were offset by higher physician costs, the authors suggest this was due largely to out-of-plan use. They also suggest that the lack of control over hospitals in those plans also contributed to their inability to compensate for higher physician costs.[34]
- "Comparative Costs to the Medicare Program of Seven Prepaid Practices and Controls," (Weil, 1976): The author compares the cost experience of Medicare enrollees in seven PHPs in 1969 and 1970 with similar persons in the fee-for-service system. Weil found that physician costs were generally higher for the enrollees due to out-of-plan use. Costs were also higher for home health services. Nevertheless, the net cost effect of enrollment in 1969 in a PGP was a $69.71 savings per enrollee and a $40.20 savings in 1970. The savings was achieved primarily through reduced hospitalization, which is shown to be especially effective in hospital-based plans. Costs for extended care facilities were also less in all PGPs except HIP.[35]
- "Use of Medicare Benefits Under HIP's 3-Year Incentive Reimbursement Experiment," (Densen, 1978): Between 1970 and 1972, HIP participated in an experiment under contract to the Social Security Administration (SSA) to demonstrate the plan's ability to maintain lower total costs and a lesser rate of cost increase for Medicare enrollees than the costs incurred by Medicare beneficiaries receiving fee-for-service care in the same geographic area. The demonstration was evaluated by the Harvard Center for Community Health and Medical Care, also under SSA contract. The evaluators found that HIP achieved a lower rate of

34. Corbin, M. and A. Krute, "Some Aspects of Medicare Experience With Group Practice Prepayment Plans," *Social Security Bulletin,* March 1975, pp. 3-11.

35. Weil, P., "Comparative Costs to the Medicare Program of Seven Prepaid Group Practices and Controls," *The Milbank Memorial Fund Quarterly: Health and Society, Summer 1976, pp. 339-366.*

increase in total costs between 1969 and 1972 (27.6 percent for HIP versus 33.1 percent for non-HIP) but did not keep total *per capita* payments below those for the non-HIP group. Both HIP and non-HIP beneficiaries decreased their use of hospital, extended care facilities, and home health benefits, while increasing their use of outpatient and Medicare Part B services. In fact, the $51 extra in physician services used by the HIP group more than offset HIP's "savings" under the experiment. On average, SSA paid $47 more *per capita* for those enrolled in HIP. Nearly one-third of HIP's Medicare enrollees obtained medical services out-of-plan in 1972 at a cost of approximately $4.5 million. About 6.8 percent of the Medicare enrollees used out-of-plan services exclusively. Only a small portion of the total out-of-plan services was not covered under HIP's contract. Most of the out-of-plan use was linked with hospital use. The HIP group also used proportionately more out-of-plan specialty physician services than the non-HIP population and tended to be more seriously ill than those who received all of their services in-plan.[36]

- "Risk Differential Between Medicare Beneficiaries Enrolled and Not Enrolled in an HMO," (Eggers, 1980): This is a case study which compares the utilization and reimbursement experience of Medicare beneficiaries before they joined Group Health Cooperative of Puget Sound (between October 1976 and July 1979) with a group of other Medicare beneficiaries in the Puget Sound area. The results suggest that this particular open-enrollment population was significantly healthier than the comparison group, especially as reflected by their pre-enrollment inpatient utilization and reimbursement. The open-enrollment group had used 52 to 62 percent fewer days of care per 1,000 than other beneficiaries and had 40 to 50 percent less reimbursement. Because of problems with the data, it was not possible to calculate utilization and reimbursement amounts for Part B services in a similar manner. Therefore Eggers compared the percentage of open enrollees and other Medicare beneficiaries who had met the $60 deductible in 1975. About 58.6 percent of the comparison group met their deductible, while only 52.9 percent of the open enrollees had done so. Eggers estimated that the open enrollment beneficiaries would have to have consumed $440 per user in Part B reimbursements to offset their lower inpatient reimbursement.[37]

36. Densen, P., E. Jones, I. Altman, and J. Miller, "Use of Medicare Benefits Under HIP's 3-Year Incentive Reimbursement Experiment," Final Report, August 1973 (HEW Contract No. SSA-70-2905). See also: "Use of Out-of-Plan Services by Medicare Members of HIP." *Health Services Research*, Fall 1978, p. 243-260. A comprehensive review of the HIP results and other Medicare HMO studies is provided in "HMOs as an Alternative Mode of Care for the Elderly," Karen Lenox, Urban Institute, April, 1978.

37. Eggers, P., "Risk Differential Between Medicare Beneficiaries Enrolled and Not Enrolled in an HMO," *Health Care Financing Review,* Winter 1980, pp. 91-99.

The methodology and results of this study have been featured prominently in HMO reimbursement policy discussions since they question a number of premises upon which Administration HMO policy is based. Among these are: (1) the accuracy of current procedures for predicting the cost of providing Medicare benefits under fee-for-service and for setting Medicare HMO reimbursement rates, and (2) the degree to which HMOs attract or promote favorable selection. These questions and others regarding reimbursement methodology are addressed in detail in other sections of this report.

Summary

Research on Medicaid eligibles enrolled in HMOs has produced no evidence of fundamental differences between the Medicaid and non-Medicaid experience. If the goal of policymakers is to promote single class medicine, this should be encouraging. There remains, however, a need for more comparative study of Medicare, Medicaid, and private sector experience in HMOs to validate this finding. An interesting place to start might be to ascertain whether Medicaid enrollees in HMOs like the Harvard Community Health Plan have fewer hospital days than other enrollees in this plan, and if so, why. Some researchers have argued that Medicaid populations have greater need for care than the employed.[38]

Available research comparing costs and utilization of HMO and non-HMO Medicare and Medicaid beneficiaries supports the findings of private sector research that HMO members cost less and use fewer hospital days. The major unknown factor in this phenomenon is the extent to which presumed HMO efficiency is related to self-selection of members. In addition, more questions need to be answered about out-of-plan utilization.

Conclusions about the use of ambulatory and preventive services are highly tentative. Evidence pointing to greater or lesser use of ambulatory services by Medicaid recipients can be found.

Medicare beneficiaries increase their use of ambulatory services in general in HMOs. The basis for this finding is extremely tentative, however, since only Eggers compared the use of services before and after joining an HMO. Eggers' study population used less ambulatory care, as well as less inpatient care.

Accessibility for HMO Medicaid recipients is probably improved as far as initial access to a provider, but Medicare and Medicaid beneficiaries may face the same delays in obtaining appointments as enrolled private sector groups. There is some evidence to suggest that the process of care for HMO Medicaid recipients is better than fee-for-service. However, until enrollment incentives other than financial ones are understood and acted upon, the likelihood of a widespread shift from fee-for-service medicine by Federal beneficiaries is highly unlikely.

38. Aday, L., R. Anderson, and G. Fleming, *Health Care in the U.S.: Equitable for Whom?* (Beverly Hills, California: Sage Publications) 1980.

Reimbursement

Medicare

Current Procedures

Section 1876 of the Social Security Act authorizes two Medicare reimbursement options: cost and risk. Cost reimbursement is essentially an application of the Medicare cost principles of reimbursement, as specified in the Provider Reimbursement Manual (although certain exceptions are permitted). The HMO is reimbursed on an interim *per capita* basis, which is established from an annual operation budget and enrollment projections. Interim estimated cost reports and enrollment projections are submitted on a quarterly basis and are used to adjust the interim *per capita* rate. A final audited cost report is subsequently submitted by the HMO. There is no requirement under cost reimbursement that the HMO's *per capita* costs should be less than the equivalent fee for service costs.

Risk reimbursement introduces the concept of the adjusted average per capita cost (AAPCC), which is defined in Section 1876:

> "The term "adjusted average per capita cost" means the average per capita amount that the Secretary determines (on the basis of actual experience, or retrospective actuarial equivalent based on an adequate sample and other information and data, in the geographic area served by a health maintenance organization or in a similar area served by a health maintenance organization with appropriate adjustment to assure actuarial equivalence, including adjustments relating to age distribution, sex, race, institutional status, disability status, and any other relevant factors) would be payable in any contract year for services covered under this title and types of expenses otherwise reimbursable under this title (including administrative costs incurred by organizations described in sections 1816 and 1842) if such services were to be furnished by other than such health maintenance organization."

Under risk reimbursement, the HMO is reimbursed its cost, and if the costs are under the AAPCC, the HMO receives 50 percent of the savings (defined as the difference between the AAPCC and cost), up to 10 percent of the AAPCC. If the costs are higher than the AAPCC, the HMO must absorb the losses, but these can be carried forward into subsequent years and can offset future savings. The current risk reimbursement is also linked to the determination of costs following Medicare principles of cost determination. The HMO is therefore unable to know, at the beginning of the service year, the expected revenue from its Medicare enrollees. This is contrary to the procedures followed by HMOs in the private sector, where they are on full risk, receive a fixed premium, and can appropriately plan and budget. Currently only one HMO, the Group Health Cooperative of Puget Sound, is reimbursed on a risk basis.

The key concept under the current risk reimbursement and proposed alternative full risk procedures, is the AAPCC. The AAPCC measures what it would have cost the Medicare program if the individuals enrolled in the HMO had received benefits in the fee-for-service sector. To calculate the AAPCC, HCFA's Office of the Actuary (OACT) does the following:

(1) determines the U.S. *per capita* cost
(2) determines the service area *per capita* cost by multiplying by the appropriate service area geographic and age-sex index (The service area represents the counties which the HMO serves.)
(3) adjusts the service area *per capita* costs by the appropriate age-sex underwriting indices to obtain HMO specific cost. (These indices adjust for differences between the service area and HMO age, sex, institutional status and welfare characteristics.)

The AAPCC thus starts with national costs, then applies appropriate indices to obtain county-specific data, and finally applies the age-sex underwriting indices to obtain HMO specific cost.

This procedure for calculating the AAPCC enables the HCFA actuaries to calculate the AAPCC for any county in the U.S. The methodology used to calculate the AAPCC was reviewed by a special panel of actuaries convened by HCFA in January 1979. The report prepared by the panel stated:[39]

> "We believe the AAPCC computation responds well to the legislative requirements in Section 1876 and that the AAPCC formula contains a sufficient level of accuracy. However, there was expressed concern about the statistical validity of the geographic factors and a suggestion that the Underwriting Index might be further validated."

There are some limitations which must be recognized if the AAPCC is adopted as the basis for new risk reimbursement procedures:

(1) The age-sex underwriting indices are based on data collected from three years of the Current Medicare Survey (CMS). CMS data were self-reported, with all the limitations this imposes, and are no longer collected.
(2) The finest level at which the AAPCC can be calculated is the county, since the age-sex and geographic indices are determined at this level. Although the capability exists theoretically to calculate these indices on a zip code level, this would require extensive computer runs. Zip code-based indices would undoubtedly be more unstable than county-based indices. On the other hand, if an HMO's service area is not representive of the county in which it is located (a problem likely to occur in counties with large cities or distinct urban and rural sectors), serious errors in the AAPCC calculation may occur.

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39. Report of the Medicare HMO Actuarial Review Panel for the Office of Reimbursement Practices, HCFA, January 1980.

(3) The calculation of the AAPCC requires placing all Medicare individuals in the service area or the HMO, by age and sex, in the following separate cells: (1) institutionalized, (2) welfare and not institutionalized, and (3) all others. The counts for these cells are established from different data sources which identify the number of individuals who are institutionalized, the number who are on welfare, and all others. The calculation requires the assumption that all institutionalized individuals are on welfare. The validity of this assumption needs to be verified.
(4) The welfare adjustment indices are based on national CMS data. The wide variation in Medicaid coverage across States may introduce an unknown bias.
(5) The age-sex underwriting indices have not been redetermined since they were calculated in 1977. There has been no assessment of their stability over time.
(6) If an HMO enrolls a significantly large proportion of its service area, it may not be appropriate to use that county to calculate an AAPCC. A neighboring county may have to be used, but this raises the issue of how to establish that the characteristics of the counties are reasonably matched.
(7) The calculation of an AAPCC currently requires approximately five weeks—two for the demographic data to be obtained from the computer files and three for OACT to perform the calculations. If a large number of HMOs enroll Medicare beneficiaries under a risk arrangement, this process must be expedited. Since most HMOs will operate on a calendar year basis, most AAPCC calculations are required by October (three months prior to the new service year, permitting the HMO to calculate and communicate new premiums). If institutional data must be obtained, they may have to be collected as early as March or April.

In addition to these limitations of the AAPCC, there are some administrative problems which arise in collecting the data necessary to determine the AAPCC.

(1) Welfare status is determined by an indicator in the Health Insurance Master Beneficiary File that premiums are paid by Medicaid. Although most States have buy-in agreements, four did not, as of March 1980: Louisiana, Alaska, Oregon, and Wyoming. Data then have to be obtained directly from the State, which may be difficult.
(2) The major administrative problem is collecting accurate data on institutionalization. The definition of institutionalized individuals used by the HCFA actuaries is: "Medicare beneficiaries residing for over 30 days in a nursing home, sanitarium, rest home, convalescent home or long-term care hospital." Since the range of institutions included in this definition is considerably broader than the skilled nursing facility (SNF) care covered by Medicare, the number of institutionalized Medicare beneficiaries cannot be obtained from HCFA files. Independent data sources, such as State Medicaid programs or independent surveys, must be used to obtain this data. A discussion on how institutional data were obtained for the demonstration sites and alternative strategies which could be used in the future can be found in Appendix B.

Determination of Prospective AAPCC

Establishing a procedure for calculating a prospective AAPCC is relatively straightforward and follows the procedure used to calculate the retrospective AAPCC. In the simplest approach, the value of all parameters used to calculate the retrospective AAPCC must be projected forward to estimate their values during the prospective service year. The HCFA Office of the Actuary has established the following procedures for projection:

(1) Calculate the U.S. *per capita* cost with the most current projection used by OACT in preparing the annual reports to Congress on the Medicare Trust Funds.
(2) Use a five year unweighted average for the geographic index.
(3) Use a five year unweighted average of the age-sex index.
(4) Assume that the age-sex underwriting indices remain constant over time.
(5) Obtain the most current data on service area Medicare enrollment (that is, individuals on welfare, institutionalized, or other) prior to calculating the prospective AAPCC, and assume that the data remain constant during the service year.

Using the above procedures, a prospective AAPCC can be calculated. However, because of the sensitivity of the issue of favorable or unfavorable selection (which will be discussed in greater detail later), OACT believes it is not appropriate to project enrollment statistics, unless no other alternative can be found. This has resulted in the development of the rate book approach, in which OACT calculates the appropriate reimbursement for each cell for which an age-sex underwriting index has been established. The HMO is thus reimbursed a different rate for enrolling a 65 year old male than for a 75 year old male or a female. Rates for 15 rate cells for each county in the HMO's service area must be calculated for both Part A and Part B. While this procedure clearly eliminates the selectivity issue from both the HMO's and the government's viewpoint, it introduces some other problems:

(1) The HMO is not able to accurately project its revenue from enrolling a fixed number of enrollees, since a different rate is established depending on the enrollees' characteristics. (However with payment based on these characteristics, the HMO assumes less risk.)
(2) The HMO must establish procedures to identify when a beneficiary becomes institutionalized, and report this as part of its accretion report to HCFA. Age, welfare status, and county of residence are determined from the Health Insurance Master Beneficiary Files. For those States without buy-in agreements, the HMO would have to be able to determine the welfare status of its enrollees. This may require HMOs to make systems modifications to accommodate Medicare procedures.

The rate book approach is only being implemented in the InterStudy demonstration. (See Appendix A for a brief description of the Medicare capitation demonstrations.) Kaiser, Portland negotiated a hybrid approach during the developmental phase of its demonstration. Kaiser would not accept the rate book approach because it would have required changes in their data processing procedure, and because they were unable to report the welfare and institutional data on a monthly basis. (Oregon is one of four States with no buy-in.) Since Kaiser did have age-sex distribution data on their current group prepaid practice enrollees, it was agreed, prior to the initiation of the service contract, to assume an enrollment distribution to calculate one interim AAPCC, which would be used to reimburse Kaiser for each enrollee. During the year, Kaiser would obtain actual counts of the age and sex mix of the enrollees, and HCFA would apply a one month count of welfare and institutionalized individuals for the full calendar year. These data are used to make a retroactive adjustment to the payment made based on the interim AAPCC.

Once an HMO has a stable enrollment, the differences between using one projected AAPCC, the hybrid approach, or the rate book will be minimal. During the initial enrollment build-up, errors incorrectly projecting an HMO enrollment mix can have a significant impact on the AAPCC, since the age-sex underwriting factors vary so widely.

Any problems in accuracy or bias in calculating the AAPCC become more sensitive when calculating a prospective AAPCC. One final example will show how difficult it is to establish a procedure that will be accurate under all possible circumstances. Consider the situation where an HMO is established in a medically underserved area. Because of access problems, Medicare beneficiaries may not be using the full range of services to which they are entitled. This would be reflected in a low AAPCC. For those beneficiaries enrolling in the HMO, these access barriers are removed, but the HMO's reimbursement is still limited by the AAPCC.

Experimental Reimbursement Procedures

The demonstration projects will test three alternative risk reimbursements: (1) percentage of the AAPCC, (2) adjusted community rate, and (3) actuarial. None of these approaches is linked to cost reimbursement. The AAPCC is used to limit the reimbursement rate of the latter two methodologies.

None of the demonstration projects exactly duplicates the 1980 Administration proposal (not adopted by the 96th Congress) which operated as follows:

(1) The HMO is reimbursed 95 percent of the AAPCC. The difference between this figure and the adjusted community rate (ACR) is defined as savings.
(2) These savings are used by the HMO to provide additional services or reduced premiums. Previous legislative proposals have listed a specific order in which savings must be applied (preventive services, reduced premiums, and additional services); the 1979 House bill eliminated the order and left the decision to the HMO.

The ACR calculation is based on adjusting the HMO's utilization and cost statistics in the private sector for the characteristics of the Medicare population. For an HMO with an enrolled Medicare population (through a cost contract or as a GPPP), the determination of the ACR is essentially straightforward. Adjustment factors are established by calculating the ratio of Medicare utilization within the HMO to private sector utilization for a specific service. (This is known as a volume factor.) For physician services, current HMO regulations permit the application of an additional 20 percent time and complexity factor. If these data are not available, the establishment of adjustment factors becomes more controversial and their accuracy problematic. The key factors that must be established are for hospital and physician utilization. The following procedures have been used:

(1) Assume that factors available from other HMOs are applicable. Kaiser, Portland has extensively published utilization data for their populations. A formula that can be applied is:

$$\text{HMO Medicare Rate} = \text{HMO Private Rate} \times \frac{\text{Kaiser Medicare Rate}}{\text{Kaiser Private Rate}}$$

Many HMOs are reluctant, however, to assume that they will initially be as efficient with a new Medicare population as well-established HMOs.
(2) Obtain data on the fee-for-service utilization experience in the service area and make appropriate adjustments. It is usually assumed that hospital days will be reduced by 5 to 25 percent, while physician services will be marginally increased. For the demonstration sites, HCFA provided Medicare utilization data by age and sex for each county in the HMO's service area.
(3) An actuarial firm will provide the HMO with utilization data based on "standard file formula" from the actuary.

The actuarial model is closely related to the ACR procedures, and sometimes the distinction is not clear in practice. Theoretically, the actuarial model builds up the rate from scratch, without linking it to the HMO's experience with the private sector. The problems of establishing HMO Medicare utilization statistics are essentially the same as those described above.

A controversial issue in setting Medicare HMO rates is how administrative costs are distributed among the Medicare program and the private sector. For example, under HMO cost reimbursement, marketing costs are allocated by member-months, although it is generally recognized that the Medicare (and Medicaid) population is more difficult and expensive to market. Large concentrations of Medicare beneficiaries, as found in private business, are not available for marketing. The ACR determination provides flexibility in adjusting for marketing costs. Use of the adjusted community rate can also reduce controversy concerning what are appropriate allowances for a retention factor for earnings and reserves. The adjusted community rate concept permits the application of the identical retention factor for the Medicare population.

A final issue which may arise in calculating the adjusted community rate is: Which community rate should be used? Large HMOs may offer many different rates which could be considered the community rate, and it is not always obvious which is the appropriate rate to adjust. Detailed, supported justification for components of the community rate may not be available. If available, the rate and supporting documentation used by the HMO to establish its rate for the Federal Employees Health Benefit Program provides an independent benchmark which can be used as the community rate.

The rate book approach for the AAPCC was established to avoid uncertainty in the HMO's actual enrollment. This uncertainty cannot be avoided, however, in establishing the ACR. To prospectively establish the ACR and estimated savings, the enrollment distribution must be assumed initially. Fortunately, serious errors should occur only for an HMO with no prior Medicare enrollment, and then only for the initial years. Furthermore, the error should only affect the determination of additional benefits that the Medicare beneficiary will receive, since the rate book approach will assume proper payment to the HMO.

Limited experience with the demonstration projects indicates that the proposal to set rates at 95 percent of the AAPCC has the strong advantage of being relatively straightforward and minimizing HCFA's review process. The actuarial approach requires extensive review and justification and becomes similar to a budget review process. The disadvantage lies in the apparent arbitrariness of the percentage actually selected. Why not 90 percent of the AAPCC, or even 80 percent, rather than 95 percent?

During the developmental phases of the demonstration contracts, great variability was displayed in the ability of the contractors to come under the 95 percent criterion. Two of the plans were able to provide significant additional benefits while being reimbursed at 90 to 95 percent of the AAPCC. One plan was reimbursed at 98 to 99 percent of the AAPCC, with limited additional benefits. The other participating projects will be reimbursed at 95 percent of the AAPCC and will provide a limited package of additional benefits. One benefit which all plans provide, but which is not always recognized as an additional benefit, is that all Part B physicians services are provided as if on assignment. There are no additional, out-of-pocket costs for these services. This can represent a significant savings to the Medicare beneficiary, since approximately 50 percent of claims are currently not accepted on assignment. Two projects were not able to establish rates below the AAPCC and were therefore not permitted to continue into the implementation phase.

Selection Issue

The most controversial issue in evaluating the adequacy of reimbursement rates for HMOs is favorable/adverse selection. There has been much debate on this matter, with the available studies providing ambiguous results. On a theoretical basis, convincing arguments can be made for both possibilities. Favorable selection should occur because individuals who already have ties with physicians (and presumably have poorer health status than the average) will not join HMOs unless they are dissatisfied with their current practitioners. On the other hand, one can hypothesize that individuals who anticipate high medical bills are most likely to change from the fee-for-service sector (with potential high out-of-pocket costs) to an HMO setting, with the knowledge that for a fixed premium, all their health costs will be covered.

In the private sector, the debate concerning favorable/adverse selection is primarily of academic or policy interest, since the HMO is permitted to set its own community rate, subject only to the competitive forces working in the marketplace. Except for specific limited conditions, a Federally-qualified HMO is not permitted to make any demographic adjustments to its community rate because of the special characteristics of its enrolled population. The HMO may reduce some possibility of adverse selection by health screening and by assuming responsibility for an individual only after discharge from an institution.

When rates are established by a government agency rather than by the HMO, the selection issue intensifies. The AAPCC should reduce some of the controversy in that it attempts to adjust for the specific demographic characteristics of HMO enrollees by controlling for their age, sex, welfare, and institutional status. Thus, even if the HMO enrolled a significantly younger (or older) population than is present in the fee-for-service sector, the AAPCC should make the proper adjustment.

The AAPCC would not, however, adjust for differences in health status within a specific demographic group. For example, in the study, "Risk Differential Between Medicare Beneficiaries Enrolled and Not Enrolled in an HMO," described above, Eggers examined the selection issue for Medicare open enrollees in the Group Health Cooperative of Puget Sound. The study compared the inpatient hospital use and associated costs by Medicare beneficiaries for the two years prior to joining GHC to the inpatient utilization and costs of Medicare beneficiaries who resided in the same geographic area for the same time period but who did not enroll in the HMO. Specifically, the study compared the Medicare claims of 887 beneficiaries who later joined GHC during one of its open enrollment periods to claims generated by approximately 200,000 beneficiaries who did not join GHC. Eggers concluded that during the

two years prior to their enrollment in GHC, the GHC enrollees' hospital inpatient utilization was 52 to 62 percent lower than that of the comparison group, after adjustments had been made for age, sex, welfare, and institutional status. The *per capita* hospital costs for those same inpatient services were 40 to 53 percent below the comparable population. Also, the open enrollees' use of Part B services appeared to be lower, as measured by the percent of people fulfilling the Part B deductible.

The Eggers study represents a methodogical approach to the selection issue which can be replicated in future studies. Comparing prior utilization of HMO enrollees to a fee-for-service control population is a much sounder approach than simply looking at age-sex distribution or utilization after enrollment, as was done in most previous studies. The results indicate that further analysis of the AAPCC methodology may be warranted. It is premature to generalize from the results of only one study. HCFA's Office of Research does plan to refine the methodology and to undertake a similar study for the current capitation demonstrations, which will offer a larger population base. It may also be useful to conduct a similar study with Medicare cost contracts which have open enrollment periods.

Should the Eggers results be verified, adjustment for health status in the reimbursement methodology or modification of enrollment procedures would be necessary. Some have argued that HCFA has not properly implemented the Section 1876 statutory requirement to consider disability status as a factor in determining the AAPCC. HCFA has interpreted this requirement as requiring the calculation of a separate AAPCC for the disabled and aged populations. Opponents of this view believe that the legislative intent was to consider health status as one of the actuarial adjustments.

It would be extremely difficult to incorporate health status in the AAPCC since there is no generally acceptable measure of health status. Even if such a measure existed, it could not simply be incorporated in the AAPCC because there are no currently available or planned Medicare national data bases which include an acceptable measure of health status and the currently used factors. It would take at least three to five years of developmental work to incorporate a health status measure in the AAPCC.

Another alternative is to address the issue of selection administratively. If one cannot incorporate health status in the AAPCC, one could closely monitor the open enrollment procedure to reduce the possibility of selection. The Eggers methodology could be used to compare prior hospital utilization of the HMO enrollees and a comparison group to monitor the open enrollment procedure. While this could be accomplished rather easily, it does not address the administrative action to be taken if either markedly favorable or unfavorable selection occurred.

A third approach might be to use a community rate, as used in the private sector. The community rate does not permit any adjustments for demographic characteristics, yet HMOs are generally flourishing. (The cynic would argue that this indicates that HMOs are experiencing favorable selection.) If a number of HMOs can demonstrate financial stability by enrolling the Medicare population on a risk basis using an AAPCC or community rating methodology, other HMOs will follow. (Of course, the cynic will then argue that this only proves that the AAPCC is biased toward the HMO.) The basic issue boils down to how complicated a risk reimbursement methodology one wishes to develop to minimize unknown factors. The only level at which one can eliminate all risk of overpayment is cost reimbursement, with all its attendant inflationary impulses. However, if the government wishes to encourage HMO contracts under Medicare, it may have to adopt a straightforward procedure for establishing the AAPCC.[40]

Medicaid

Current Procedures

On May 9, 1975, the Department published HMO regulations which included requirements for establishing Medicaid capitation rates. The regulations require:

- that the State agency specify the actuarial basis for computation of the premium rate or subscription charge specified in the contract;
- that these rates or charges be reasonable; and
- that the State pay no more than the equivalent *per capita* cost that would have been paid on a fee-for-service basis.

Two general approaches are being used to meet these broad requirements: fixed percentage of the equivalent fee-for-service costs and the actuarial approach. The fee-for-service percentage is attractive to States because it is administratively straightforward and assures a savings over expenditures which theoretically would have been incurred had the Medicaid recipient not been enrolled in the HMO. The fee-for-service percentage can also result in savings for HMOs, particularly those which achieve the reductions in inpatient utilization typically realized by efficient plans. By the same token, some view such potential for savings as too susceptible to under- or overpayments to the HMOs.

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40. The opposite viewpoint is presented in a recent Urban Institute publication, *National Health Insurance: Conflicting Goals and Policy Choices,* edited by Judith Feder, John Holahan, and Theodore Marmor. The authors argue that "present methods of calculations of the adjusted average per capita cost are extremely crude. Other variables [besides those currently used] likely to be highly correlated with the elderly's use of health services would include the presence and kind of chronic illness, Medicaid eligibility, availability of private insurance, conversion and open enrollment status, income, education, marital status, and living arrangement."

The chief advantage of actuarial rate-setting is that the results should mitigate the potential for adverse selection risk to the HMOs and favorable selection risk to the State. However, actuarial rate-setting requires front-end development of a reliable HMO information system which will not, by its own administrative burden, discourage plans from contracting. Moreover, the State must have the technical expertise to apply actuarial rate-setting methods.

PHRED and the Evolution of Rate-setting in California

In the early years of the PHP program in California, the State negotiated rates independently with each plan. Negotiators used 90 percent of the fee-for-service *per capita* equivalent costs as the overall target but permitted considerable variation among the plans. Some of the rates even exceeded the fee-for-service equivalent costs. In the aggregate, the plans' rates were in the range of 83 to 85 percent of fee-for-service rates. California responded to overall dissatisfaction with this rate-setting approach in 1974 by developing standard rates for the four aid categories for each county. The method essentially was to apply the same percentage increase to PHP rates as was projected for the fee-for-service budget. But this did not mollify the critics. The PHPs, State and Federal auditors, and Congress called in unison for the State to adopt a rate-setting method which incorporated contemporary standards of actuarial analysis.

Recognizing the difficulties in this, HCFA supported the Prepaid Health Research, Evaluation, and Demonstration (PHRED) project in California, which had as a major goal the development of an actuarially sound rate-setting methodology to be implemented by the State. PHRED staff were also asked to analyze the adverse selection issue which had arisen in connection with the capitation payment to the Foundation Community Health Plan (FCHP).

Because of delays in implementing the project, it was impossible for PHRED to undertake a small scale demonstration and have it used by the State in time for the fiscal year 1977-78 rates. Instead, PHRED attempted to apply actuarial methods to set rates for all PHPs, while at the same time, the State analysts replicated their traditional method of projecting increases. The statistical reports being submitted at that time by the plans aggregated all four aid categories. Because these reports formed the major source of data for rate-setting, and because AFDC represented 87 percent of PHP enrollees and 83 percent of the capitation payments, PHRED was able to calculate fiscal year 1977-78 actuarial rates for AFDC only.

PHRED's actuarial methods built upon the recommendations of an earlier series of reports prepared by the Martin Segal Company for the State. The model, developed from these recommendations, considers three principal factors: demographics, utilization, and costs. The ironic outcome of this rate-setting demonstration was that the aggregate actuarial AFDC rate was $34.84, and the traditionally set rate was $34.89—both about 83 percent of fee-for-service. PHRED offers two explanations for this parity: (1) the possibility that global assumptions suffice in actuarial work related to health care costs, and (2) that the 83 percent of the fee-for-service rate set arbitrarily in earlier years turned into a self-fulfilling prophecy for future costs and utilization.

A major product of PHRED under this component of the project was their "Ratesetting Guide for Prepaid Medicaid Contracts." This guide is designed to assist Medicaid agencies with the policy and technical issues of actuarial rate-setting for prepaid Medicaid contracts. The guide includes chapters on:

- the conceptual model
- determining the fee-for-service maximum
- determining the community rate maximum
- other actuarial rate-setting methods (that is, cost modeling, budget modeling, and community rate adjustment)
- adjustment factors
- risk sharing
- administration

For the fiscal year 1978-79 rates, the California Department of Health Services used the PHRED model for all four aid categories. This was largely facilitated by the passage in September 1977 of a State law (AB 1693), mandating accessibility to PHP data and empowering the State to specify what data it would collect. The law also requires the California Department of Health Services to use actuarial rate-setting methods and specifies age, sex, and aid category as minimum demographic characteristics that must be included in such methods. That year's rates set by the Department were developed in the following steps:

(1) The State used experience data reported by PHPs to develop utilization and cost assumptions.
(2) Cost assumptions were projected in accordance with current Consumer Price Index trends and Medi-Cal fee-for-service trends.
(3) Increased PHP responsibility for mental health services and child screening increased the rates; they were reduced for "other insurance" recovery.
(4) For the adult aid categories (ATD, OAA, AB), adjustments were made for Medicare coverage.
(5) For AFDC, the standard rates were adjusted to the utilization experience of each PHP (that is, an age-sex adjustment was applied).
(6) For ATD and OAA, the standard rates were adjusted to the utilization experience of each PHP.
(7) For ATD and OAA, a risk-sharing rule was developed.[41]
(8) To reflect the impact of reduced abortion coverage, adjustments were made for risk-sharing related to possible delivery rate increases.
(9) Resulting rates were compared with fee-for-service *per capita* costs and with PHPs' commercial rates.

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41. For a detailed discussion about risk-sharing, see the article written by the former PHRED project director, Rigby Leighton: "Risk Sharing: A New Reimbursement Alternative" (in *Perspectives on Medicaid and Medicare Management*, September 1979, HCFA-79-20021). In addition to outlining general principals of risk-sharing, the paper describes a form of selective risk-sharing being used by California.

As a result of that year's rate analyses, the State discovered that the rates previously paid for the ATD, OAA, and AB aid categories were significantly higher than could be justified on the basis of actual PHP utilization in these categories. Since this finding cast doubt upon the validity of the actuarial assumptions, a risk-sharing formula for these categories was developed for the 1978-79 rates: The plan and the State shared risk for cost effects of increases in utilization between 100 percent and 150 percent of the plan's experience-based utilization assumptions. All costs in excess of 150 percent were borne by the State to a maximum of the fiscal year 1977-78 aggregate rates. In effect, then, the plan is held accountable only for those cost effects over which it has direct control.

The Department of Health Services ran into opposition from the State Department of Finance in gaining approval of the rates developed as described above. The Department of Finance opposed actuarial rate-setting primarily on the grounds that tying rates to cost and utilization experience put the State in the same position with HMOs as it was in with other providers receiving cost reimbursement. The Departments ultimately reached a compromise in which rates were derived by the traditional projection method and adjusted for AFDC by PHRED's age/sex factors.

The PHRED project also examined the adverse selection issue in an IPA setting. During the 1972-76 period, the Foundation Community Health Plan (FCHP) was an IPA model PHP contracting with the State of California. The capitation rates paid by the State to FCHP were unusually high. In 1974, the FCHP capitation rates were approximately 16 percent higher than the estimated *per capita* costs for the non-enrolled Medi-Cal beneficiaries in the five county area served. In contrast, the capitation rates for the other PHPs averaged about 15 percent less than fee-for-service *per capita* costs.

The State and FCHP originally justified the higher rates by arguing that FCHP experienced adverse selection. California responded as follows:

> "The Department of Health allowed higher rates because the FCHP enrollees include a disproportionate number of sick people. The Department concluded that this was the case because the FCHP made enrollments through physician offices and those enrolled were, therefore, in more need of medical care."[42]

This is the crux of the argument often made by IPAs of why they experience adverse selection.

When HEW declared an audit exception because of the alleged overpayment, the PHRED project analyzed the utilization experience of FCHP enrollees and fee-for-service beneficiaries in the five county Sacramento area. (Regulations do not permit capitation payments to HMOs higher than the fee-for-service maximum.)

The PHRED report first examined the claim that enrollment through physician offices had resulted in adverse selection and discovered the claim could not be supported. The great majority of individuals had enrolled in FCHP prior to the effort to have member physicians promote enrollment. The tenuousness of this adverse selection argument is further supported by PHRED's reasoning as to why adverse selection may have occurred:

> "Our conclusion is that the "enrolling through the doctor's office" image is specious, a convenient myth that became increasingly credible through repetition. The irony of the situation is that FCHP may have experienced adverse selection for exactly the opposite reason—the organization undoubtedly assigned a primary care physician to a significant number of individuals who previously did not have a personal physician. (California requires that each PHP enrollee be assigned to a primary care physician.) Each such individual thereby had a higher degree of access not only to physician services but to all those health care services for which a physician is the 'gate keeper.' "

In testing this hypothesis, the PHRED project did not have access to utilization experience of FCHP enrollees and a control group prior to enrollment (as was used in the Eggers study) and had to rely on actual utilization subsequent to enrollment. A simple comparison of age and sex indicated no difference between the two groups. (Age-sex adjustments constitute the only actuarial adjustment used by the State in establishing HMO rates.) Since differences in utilization could have been caused by either favorable/unfavorable selection or variations in utilization control mechanisms, the PHRED analysis attempted to control for the latter variable and hence assign any utilization differences to the selection factor.

This was accomplished through two key assumptions:

(1) Acute hospitalization—the most expensive single category of service—was subject to the same utilization control, the Certified Hospital Admission Program.
(2) FCHP controlled utilization for other services similar to those used by the State fiscal intermediaries.

The analysis of utilization patterns indicated that, for the AFDC population, adverse selection occurred in terms of ambulatory services, but favorable selection occurred in terms of acute hospital care. For ATD, the utilization pattern showed substantial adverse selection for both ambulatory and acute hospital care. Adverse selection was defined as increased utilization of services.

The PHRED analysis presents a careful methodology for analysis of the selection issue based on actual utilization in the HMO, but the validity of the results can only be accepted if the key assumptions are confirmed. The Eggers methodology eliminates the necessity of making these assumptions.

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42. "The FCHP Audit Exception: Evaluation of the Adverse Selection Hypothesis." PHRED Report, July 1977.

Marketing

Medicare

There are two primary problems in marketing HMOs to Medicare beneficiaries. Identifying the Medicare population presents the first obstacle. Many HMOs believe that direct mailing of literature to Medicare beneficiaries would be effective, but HCFA is precluded by the Privacy Act from furnishing lists to HMOs of Medicare beneficiaries' names and addresses. To partially overcome this problem, HCFA's Group Health Plan Operations Staff makes direct mailings to beneficiaries in HMO service areas, notifying them in standard language that there are one or more HMOs in the area that serve Medicare beneficiaries. The message does not explicitly advocate HMO membership, and it does not give details on the specific HMO's characteristics.

The second problem in marketing to Medicare beneficiaries is cost. Even after the population has been identified, perhaps at considerable cost, individuals must be reached. Unlike the private sector, there are generally no employer groups or unions through which information can be conveniently disseminated. Often, the HMO must resort to one-on-one presentations. Current Medicare cost-based reimbursement mechanisms provide for some reimbursement of marketing costs, but the amount is inadequate in many cases. Under Medicare reimbursement principles, HMOs are allowed to allocate marketing costs among programs on an enrollee basis, but this does not reflect the relatively greater cost of marketing to the Medicare population. HMOs thus have little incentive to market aggressively.

Demonstration Marketing Procedures and Results

FALLON COMMUNITY HEALTH PLAN: The Fallon Community Health Plan obtained a mailing list from Blue Cross of Massachusetts of all Medicare supplemental policyholders, which they used to disseminate literature in Worcester County, Massachusetts. However, Fallon's main effort focused on its "health fair" at the Fallon Clinic held prior to its enrollment campaign. The health fair offered descriptions of the Senior Plan to potential enrollees, tours of the Fallon facilities, and several booths and exhibits dealing with a variety of topics, including safety, retirement, and chronic illnesses (for example, diabetes).

Approximately 4,000 people attended the health fair. In addition, Fallon held five open houses, attended by a total of 400 to 500 people, in which talks on the Senior Plan were given and tours of the Fallon facilities were arranged. Fallon also placed newspaper ads in two major newspapers and three small local ones. The ads contained a card that interested readers could send in to receive a brochure and application. Fallon received over 3,000 returned cards.

Fallon began its marketing efforts on February 7, 1980 and within a month had met its first year projection of 3,600 enrollees. (Its open enrollment period was terminated at that point.) This enrollment effort was much more successful than those experienced by other HMOs under Medicare contracts, which usually resulted in enrollment of only a few hundred beneficiaries in the first year.

Fallon's second year open enrollment period lasted from September 15 through January 10, 1981. Approximately 23,000 non-group Blue Cross/Blue Shield "Medex" subscribers received an application and brochure. Prior to this mailing, 900 beneficiaries on a waiting list were sent applications. The Fallon Clinic held five more well-attended open houses and gave several presentations for senior citizens groups. Newspaper advertising with return coupons was repeated, and marketing representatives contacted employer-retiree groups. A 20 percent penetration rate was achieved in a large industrial company with over 500 retirees. Since the program began, approximately 150 members have disenrolled. (This figure includes 57 deaths.) At the close of open enrollment, 1,700 more Medicare beneficiaries were enrolled. The marketing projection for Medicare enrollment in the first quarter of 1981 was achieved, bringing Fallon's Medicare penetration in its service area to nearly 10 percent.

The generous benefit package probably explains much of Fallon's enrollment success. Under the project, Fallon's Adjusted Community Rate was low enough, compared to area fee-for-service costs, that the plan could offer enrollees several benefits not covered by Medicare, including eyeglasses, preventive services, reduced coinsurance and deductible expenses, and reduced drug costs. Fallon's marketing techniques may also explain its success.

MARSHFIELD: Marketing activities at Marshfield began in April 1980. Like Fallon, Marshfield concentrated its efforts on local meetings with elderly residents and senior citizen groups. In the Marshfield area, 29 meetings were held in town halls, armories, and other public meeting places, and they were announced in advance in local newspapers and on the radio. The meetings were generally well attended and resulted in over 2,700 enrollments in the first three months. Approximately 3,550 people attended these meetings, indicating that over three-quarters of the people who attended the meetings actually joined the plan.

In addition, Marshfield set up a special enrollment desk in the Marshfield Clinic, and of the plan's first 6,200 enrollments, approximately 2,600 enrolled at the clinic. Marshfield speculates that this group may represent an adverse selection because people who enroll at the Clinic are users of services, almost by definition. Marshfield's total enrollment of 6,200 represents approximately one-third of all eligible Medicare beneficiaries in the service area. As of September 1980, 10 renal beneficiaries had also enrolled in the plan. Marshfield is holding continuous open enrollment.

Unlike Fallon and Kaiser, Marshfield was not able to offer a particularly generous benefit package under its capitation rate. Its initial success was probably a function of the popularity of the plan among the non-Medicare population. (The plan has approximately a 40 percent penetration rate in the non-Medicare community.) Moreover, since the same providers render most

fee-for-service as well as prepaid care in the area, people did not have to break existing provider relationships to join the HMO. Marshfield's second marketing campaign, which began in October, was not as successful as the first. The plan's goal was to enroll 12,000 Medicare beneficiaries by March 1981. As of the end of February, 7,929 new members had joined. The plan mailed literature and held public meetings, but newspaper advertising was minimal. The demonstration attempted to attract more institutionalized enrollees through a special mailing to responsible family members or guardians. From 38 mailings, six persons joined.

KAISER: Kaiser's campaign featured TV ads, a first for Kaiser. There was some initial reluctance on Kaiser's part to run the ad because of a sensitive relationship with the rest of the medical community. Kaiser also sent letters to its Group Practice Prepayment Plan enrollees explaining the program and suggesting they share the information with eligible friends and relatives. Kaiser began its marketing efforts in late May 1980 and reached its first year enrollment projection of approximately 6,330 by mid-summer.

The reasons for Kaiser's enrollment success may be similar to Fallon's. Its ACR was low enough to enable it to eliminate deductible and coinsurance for enrollees, and to provide routine physical exams, exams for eyeglasses, most immunizations, and full coverage for prescribed home health care and non-psychiatric outpatient mental health services. In addition, Kaiser has an advantage in that it is a large, well-known organization.

As part of its first enrollment period, Kaiser conducted a study to determine which additional benefits were most attractive to potential enrollees. All beneficiaries were randomly assigned to one of two groups:

Group I

Medicare-coordinated (M-Plan) coverage without payment of dues

Group II

Choice of one of four options listed below:

- Option A was the same as Group I above—no M-Plan dues (Options B-D required higher dues than Option A; however, they provided additional benefits not included in the M-Plan);
- Option B provided prescribed drugs at $1 per prescription, prepaid eyeglasses, and hearing aids ($6 premium);
- Option C provided dental care and dentures ($9.81 premium); and
- Option D provided prescribed drugs at $1 per prescription, prepaid eyeglasses, hearing aids, dental care, and dentures ($15.81).

After two months of applications, enrollment in the various options was as follows:

Benefit Option	Percent Enrolled
Medicare Plus (no premium)	15%
Medicare Plus and drugs/vision/hearing aid ($6)	50
Medicare Plus and dental ($9.81)	5
Medicare Plus and drugs/vision/hearing aid/dental ($15.81)	30

Subsequently, all beneficiaries will be offered the choices available to Group II.

Conversions and Disabled Beneficiaries

In each demonstration, a few enrollees represent conversions, that is, people who are members of the HMO under existing employer group contracts, and turn 65 or become disabled. These people are easy to identify and contact because they are already HMO members. So far, they represent only a handful of people under the Fallon and Marshfield contracts, but they will grow in number during the demonstration. Kaiser has a large number of conversions from its existing GPPP contract with Medicare, which covers Part B services only. The number of GPPP conversions was limited to 1,500 out of the first 4,500 enrollees.

An interesting finding from the Fallon and Marshfield demonstrations is that almost all the enrollees are aged, with very few disabled beneficiaries represented. This is not surprising, given the emphasis on the aged in the marketing materials and various benefits to the elderly of joining. Fallon actually refers to its program as the "Senior Plan." Although the marketing efforts have obviously been very persuasive with the elderly population, the results suggest that more could be done in targeting some of the marketing efforts to the disabled, who compose close to 10 percent of the Medicare population.

Medicaid

HMOs may decide to pursue a Medicaid contract for several reasons. Some see it as a legitimate means to expand membership and increase revenues. Some view a Medicaid contract as a social responsibility. For some, all of these considerations are important. However, while 30 States have HMOs within their boundaries, only 17 contract with them. Obstacles to both the State and the HMOs to contracting to serve Medicaid recipients have been identified in this paper and elsewhere.[43] States are especially reluctant to inadvertently

43. Morris, S., "Obstacles to Expanded Prepayment under Medicaid HMO Contracts" June 1980. Internal HCFA Paper.

replicate the California experience. To avoid doing so they see a need to closely monitor HMO marketing practices, but cannot or do not wish to divert current staff or hire qualified persons to do this job. In States which do have the desire and capacity to manage HMO contracts, many HMOs simply do not feel that any advantages in contracting outweigh the difficulties in obtaining qualification, establishing capitation rates, assuming risk, fulfilling reporting requirements, and providing certain benefits which are part of the State plan but may place an untenable burden on the HMO (for example, EPSDT screening or dental care).

Perhaps the most significant deterrent that an HMO considers before contracting with the State is how to market itself to the Medicaid population. The need for effective, inexpensive Medicaid marketing is important to HMOs for two reasons. First, although a core of enrollees usually retains Medicaid eligibility for appreciable periods of time, many others do not. Besides having to continually educate new people about using the system, the HMO must be able to attract these new enrollees on an ongoing basis.

Second, and perhaps more importantly, most States' HMO rate-setting procedures do not provide sufficient funds for effective marketing. If a State sets HMO rates on a percentage of fee-for-service, it may not recognize that fee-for-service payments do not include a marketing component. If a State sets its rates actuarially, it may not be willing to pay more than it costs the HMO to market to the private sector. Such a position fails to consider that private sector marketing is done largely on a group basis—hence economies of scale are probably achieved. HCFA is currently exploring a regulatory change to allow cost contracts between States and qualified HMOs. If these regulations are eventually approved, they may provide an avenue for recognizing the full costs to HMOs of marketing to the Medicaid population.

The problems in designing a Medicaid marketing strategy begin with identifying the target population. Title XIX confidentiality provisions prohibit the release of names. This had led a number of States, including California, to permit door-to-door canvassing in neighborhoods known to have large numbers of residents receiving welfare payments. Although expensive, door-to-door marketing can be effective in producing enrollments. Some have suggested that this is because the poor have traditionally responded best to peddling as a sales technique.[44] However, door-to-door marketing is generally viewed as too conducive to unethical pressure on the recipient to enroll. In California, the opportunity for this was even greater in the early years of the program since the PHP salespeople were permitted to finalize enrollments in recipients' homes. Today, in those States where door-to-door presentations are still made, enrollments are completed elsewhere to ensure that the prospective enrollee fully understands the choice he or she is making.

PHRED Membership Studies

Besides door-to-door, two other marketing alternatives are currently used to enroll Medicaid recipients: (1) State mailing of brochures to recipients explaining that they have a choice between an HMO in their area and seeking care where they can find a provider willing to serve them, and (2) various presentation methods in the welfare office. The PHRED project, which is completing the Membership Studies component of its grant, has shed some light on the comparative costs and benefits of these alternative marketing strategies. Besides developing model grievance and disenrollment systems for the plans, the major thrust of Membership Studies was to demonstrate and evaluate alternative methods of identifying the marketplace and motivating enrollment. The Membership Studies demonstrations were based on the assumption that the joint eligibility process for welfare and Medicaid affords the best possibility for replacing door-to-door solicitation as a cost-effective locale for enrolling the number of recipients necessary for viable contracts.[45] PHRED tested five marketing methods in seven welfare offices in northern and southern California. The welfare office methods included (1) a printed brochure with no personal explanation, (2) a film, (3) a personal presentation by a county eligibility worker, (4) a similar presentation by a specially trained member of the PHRED staff, and (5) a personal presentation by an HMO sales representative. In addition, literature was mailed to all eligibles in the geographic areas served by the demonstration sites' welfare offices. The plans' current marketing approaches (door-to-door, member referrals, conversions) served as the control.

PHRED's preliminary evaluation of the 5,913 choices made in welfare offices under the demonstration has resulted in the following initial findings:[46]

(1) Marketing in the welfare offices can yield a sufficient enrollment of Medicaid AFDC beneficiaries to permit elimination of door-to-door solicitation without adverse effect on the viability of the health plan contracts. State-wide enrollment would increase as a result of the full implementation of the demonstrated approaches, although impact on individual contracts may vary. Out of 5,913 choices, 951 (or 16 percent) were for an HMO.

(2) All methods tested produce enrollments, but some methods are more uniformly productive than others. Results of some seem to reflect local conditions rather than performance of the

44. Greenberg, B.S. and B. Dervin, 1979. *Use of the Mass Media by the Urban Poor.* New York: Praeger; Caplovitz, D. 1963. *The Poor Pay More.* New York: The Free Press of Glencoe.

45. Owen, E., "A Preliminary Report on the Marketing Demonstration Results from California's Prepaid Health Research Evaluation and Demonstration (PHRED) Project," 26 September 1980, Unpublished.

46. Ibid.

method itself. Table 1 indicates the results of the 5,913 presentations:

TABLE 1
Choice Rates by Method

Welfare Office Methods	Overall Choice Rate for HMOs	Range by Sites
Written Materials	12%	0.23—26%
Film	19	7—35
Eligibility Worker	13	2—17
State Staff	10	7—28
HMO Representative	22	4—32
Other Methods		
Mail	4% response indicating interest or enrolling directly in HMO	
Control	18	

(3) Costs for marketing in the welfare office are less than the plans' current methods. Welfare office enrollments cost about $9 per person enrolled, whereas door-to-door marketing costs between $45 and $50 per person enrolled.

(4) Follow-up interviews of 1,200 persons who made choices in the welfare offices indicated that those who chose HMOs were twice as likely to score more than 50 percent correct answers about their options and choice than those who chose fee-for-service.

(5) Medicaid beneficiaries in the welfare offices are able to make informed choices despite the pressure for funds, food, or other immediate needs which bring them to apply for welfare. Of 5,913 presentations, only 41 did not choose.

(6) A survey of some of these beneficiaries indicated that 22 percent elected the HMO to get "better service." About 21 percent thought the HMO would be more convenient, 13 percent believed the HMO to be "better than the fee-for-service card," and 11 percent cited previous experience. NIne percent had no previous source of care, and 16 percent had other reasons. Of those choosing fee-for-service, 31 percent indicated that they did not wish to sever established provider relationships, 11.5 percent cited convenience, 9 percent wanted freedom of choice, 7.5 percent noted familiarity with the fee-for-service system, and 41 percent had other reasons.

AB 1693, California's legislative response to the PHP scandals, authorized the Director of the Department of Health Services to prohibit door-to-door marketing after January 1, 1979, if suitable methods had been found to replace it. The law also enabled PHRED to test and evaluate new marketing techniques. The Department of Health Services is presently writing the regulations to abolish door-to-door marketing. Based on the experience of Membership Studies, the State plans to offer dual choice to Medi-Cal eligibles in the county welfare offices as part of the welfare determination process. Presentations will be made by State-paid county employees who will be trained and closely monitored by the State.

Although the data suggest the adoption of presentations by HMO representatives, a number of drawbacks to that method limit its desirability in California, and perhaps elsewhere. These drawbacks include:[47]

- cost to plans
- residual negative attitudes of welfare workers toward health plans
- opposition by California Medical Association
- limited space in welfare offices for more than one or two HMO representatives
- the insignificant penetration difference resulting from presentations by State versus HMO representatives.

There are two other legal factors which probably make the HMO representative method impractical. First, Title XIX confidentiality provisions would require that the HMO enroller not know the beneficiary's identity until the beneficiary chooses to reveal it. Second, no provider can be accorded special access to patients. Therefore, if a welfare office permits an HMO to market on its premises, it may have to provide the same access to other providers.

California is also anticipating the passage of a bill which calls for a mandatory choice by Medi-Cal eligibles during the welfare determination process. Enforcement of the mandatory choice, however, has generated controversy. At first, the State proposed to consider non-choosers as "entitled, but not covered," as a private employer would regard someone who had not selected a health benefits plan. The counties opposed this on the grounds that non-choosers would present themselves at the county hospitals with no evidence of coverage. The California Medical Association opposed the issuance of a special card to non-choosers in favor of the fee-for-service card. It now appears that non-choosers will get the latter card, but the State believes that the intent of the law—to place responsibility for choosing on the beneficiary—will still be maintained.

Massachusetts Case Management

Regardless of the relative effectiveness of the person or the medium used to encourage a Medicaid recipient to enroll in an HMO, there are disincentives to choosing an HMO which might be overcome only through legislative or regulatory change or, on a limited basis, through demonstrations. In the private sector, Luft has shown that the majority of HMO members enrolled for economic reasons. In effect, the HMO savings is being passed on to the enrollee in reduced premium payments, often accompanied by

47. Conversation with Elizabeth Owen, PHRED Project Director, July 1980.

additional benefits. Medicaid enrollees, however, cannot presently share in the savings realized by their joining the HMO or receive cash payments which would compensate them for limiting their care to one cost-effective provider, nor can an HMO offer additional benefits not covered under the State plan.

Preliminary evaluation results from the Massachusetts Case Management Grant, which offers a monthly $7 incentive payment to AFDC recipient families who agree to enroll with a provider, indicate that shared savings provide an effective stimulus to enroll in a system which restricts access. Case Management was implemented in July 1979 at four fee-for-service provider sites (two hospital-based and two community health centers). These providers share savings with the State between the annual costs of case-managed and non-case-managed care in the same region. Preliminary cost and utilization analyses for three of the sites showed an $81,000 net savings at a community health center and hospital-based clinic and no savings at another hospital-based site. In October 1980, the State signed contracts with two new sites (one health center and one group practice) which have adopted risk-sharing reimbursement methodologies. As of that time, the project had enrolled 1,640 families (36 percent of the target set for April 1981). Increased marketing staff at the new risk-sharing sites, along with radio advertising, have been credited with more successful enrollment results at these sites.

Guaranteed access to care is the chief selling point with which HMOs currently motivate Medicaid recipients to enroll in their plans. Experience has shown that in most places, this simply is not enough to make a difference. ORDS is implementing demonstrations in Hawaii and California to determine whether guaranteed eligibility, as well as cash payments, can serve as additional inducements for Medicaid eligibles to enroll in HMOs.

Multnomah County (Oregon) Project Health

An alternative approach to marketing, the broker concept, was introduced by Multnomah County Project Health. The goal of the project is to permit the State of Oregon to test the effectiveness of a multiple choice delivery system for the medically needy, ultimately leading to passage of legislation of a state-wide medically needy program. The project has also functioned as a laboratory for testing the response of low income families to trade-off decisions, where the health plan of choice may mean more copayments and/or higher premiums.

As Project Health evolved, the county developed a system of contracts with the private provider community involving (1) full-risk capitation contracts with prepaid health plans and (2) fee-for-service contracts with individual providers. HCFA has supported the project since January 1976 by granting waivers to the State's medical assistance plan. Since 1976, Project Health has served an average of 2,000 medically needy beneficiaries. Seventy-five percent of the medically needy population is currently served by prepaid contracts.

At the time of enrollment, those beneficiaries not automatically assigned to the fee-for-service program because they are institutionalized are given a choice among the prepaid plans. If the beneficiary chooses the lowest cost prepaid plan, the premium for that plan is paid entirely by Project Health. If the beneficiary elects a higher cost plan, then s/he shares in the premium cost. The amount of premium share is dependent upon, but not equal to, the difference between the chosen plan's premiums and those of the lowest cost plan. Prepaid plans may also use copayment and deductibles as beneficiary cost-sharing methods. All members of Project Health are given a comprehensive scope of benefits, regardless of the plan selected. Table 2 shows that beneficiaries will elect to enroll in higher cost plans despite the premium charge.

TABLE 2

Comparison of Enrollment in Project Health Prepaid Plans*

Project Health Plan	Average Quarterly Enrollment Number of Families	Percentage of Total Enrollment	Client Monthly Enrollment Fee for Family of Three		Capitation Cost
			Minimum	*Maximum*	
Kaiser	368	28	$1	$10	$ 98
Cascade	99	8	2	17	128
OPS	318	24	5	50	235
UOHSC	61	5	3	32	171
PMH	70	5	5	52	233
OPS-PROV	11	1	4	40	192
Fee-for-Service	387	29			

*Data taken from Third-Year Evaluation of the Medicaid Demonstration Project in Multnomah County, Touche Ross and Company, September 30, 1979.

The project has shown that medically needy beneficiaries are willing and able to share in the cost of prepaid plan premiums. This willingness is particularly evident when cost-sharing is necessary to maintain a pre-existing provider-patient relationship.

Quality of Care

Current Procedures

Section 1301(c) of the HMO Act of 1973 provides authority to establish the quality assurance requirements HMOs must meet to become Federally-qualified and remain in compliance. Since Medicare and Medicaid contract almost exclusively with qualified HMOs, these statutory and regulatory requirements affect Federal beneficiaries as well as employed persons enrolled in HMOs.

Section 1301(c)(8) requires that each qualified HMO:

> "have organizational arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for its health services which program (a) stresses health outcomes, and (b) provides review by physicians and other health professionals of the process followed in the provision of health services;"

Section 1301(c)(11) further requires that each qualified HMO:

> "provide, in accordance with regulations of the Secretary (including safeguards concerning the confidentiality of the doctor-patient relationship), an effective procedure for developing, compiling, evaluating, and reporting to the Secretary, statistics and other information (which the Secretary shall publish and disseminate on an annual basis and which the health maintenance organization shall disclose, in a manner acceptable to the Secretary, to its members and the general public) relating to (a) the cost of its operations, (b) the patterns of utilization of its services, (c) the availability, accessibility, and acceptability of its services (d) to the extent practical, developments in the health status of its members, and (e) such other matters the Secretary may require."

The Office of Health Maintenance Organizations (OHMO) is currently implementing a quality assurance strategy for HMOs based on requirements for an internal and external program.[48] The broad requirements for an internal quality assurance program stipulate that:

- The program must be supervised by a physician in the HMO and involve a broad spectrum of health professionals in the HMO.
- The responsibility for review cannot be delegated to an outside party.
- Current activities of the HMO, such as personnel selection and laboratory controls, may be identified as part of the HMO's overall quality assurance program.
- The program must provide for a systematic and documented approach involving both inpatient and outpatient settings.

OHMO suggests Medical Care Evaluations (MCEs) as a flexible way to meet these requirements which can be easily integrated with HMOs' other quality activities. MCEs offer a single review approach, regardless of the source of the premium payment. Moreover, the cost of MCEs can be recognized in the capitation as an overhead or administrative expense. OHMO recommends that HMOs' quality assurance programs not be limited to physician-related health care, but include care provided by all professionals in the HMO. Topics can be selected in any area where problems may exist, but should be relevant to patient well-being. The responsibility for selecting topics for MCEs and conducting them should rest with "a discrete committee within the organization with clearly defined lines of communication to those responsible for implementing changes." While OHMO sets no numerical requirement, it does indicate that each HMO should implement a program which systematically examines all major areas of care and prioritizes problems for study and corrective action.

Although a number of well-established HMOs have quality assurance programs which could easily meet these guidelines, OHMO anticipated that developing HMOs would require technical assistance in implementing an internal program and that they may also require 12 to 18 months' experience with their internal programs before an external assessment is conducted. In November 1979, OHMO awarded a $67,000 technical assistance contract to InterQual, Inc., Chicago. The firm has since provided over 20 on-site consultations to HMOs which requested their assistance and is preparing a technical manual on how to design an HMO quality assurance program.

The second component of OHMO's quality assurance strategy—external review—will ensure that qualified HMOs can assure quality of care. The external review strategy calls for delegation of responsibility to an independent organization. OHMO is negotiating a contract with the National Committee for Quality Assurance, Inc. to develop review procedures and standards. Consulting physicians trained by the National Committee will conduct on-site HMO reviews. Each HMO will be externally assessed every three years; however, if evidence of a serious interim problem surfaces, a "for-cause" assessment would be conducted upon referral by OHMO to the National Committee.

The physicians who review particular HMOs will be from similar type HMOs (that is, group, staff, or IPA). The National Committee will report to OHMO on the status of ongoing quality assurance efforts in HMOs and investigate "for cause" under a detailed protocol for ensuring confidentiality. Approximately 12 routine assessments are scheduled for fiscal year 1981. The Committee will also attempt to define and identify

48. "Quality Assurance Strategy for HMOs." OHMO, USPHS, DHHS, Rockville, Maryland, September 1, 1979.

measurement techniques for "availability, accessibility, and acceptability" of services.

HMOs and PSROs

Section 1155(e)(1) of the Social Security Act authorizes Professional Standards Review Organizations (PSROs) to use the services and accept the findings of the review committee of a ". . . health care facility or organization." In the past, PSROs have delegated concurrent review and MCE functions to some hospitals, some of which are owned by HMOs. However, a recent HHS General Counsel decision indicates that the law also authorizes PSROs to delegate directly to HMOs the responsibility for review of their members, including those HMOs which do not own the hospitals to which their patients are sent. HCFA is writing a new chapter of the PSRO Program Manual which will set forth the criteria for delegation, as well as the agreements that should be signed by the PSROs, HMOs, and hospitals involved.

For an HMO to obtain responsibility to review its Federal enrollees, it must request permission from the PSRO. Unless waivers are granted, a delegated HMO must use PSRO norms and criteria for reviewing Federal enrollees. In delegating review to an HMO, PSROs should recognize that, while the fee-for-service system review focuses on over-utilization, the review of HMO patients should focus on potential under-utilization.

The rationale for allowing HMOs to conduct their own review is partly to avoid duplication of effort in the review of Federal beneficiaries. Delegation should also eliminate the potential for a PSRO to deny a hospital bill for a Medicare beneficiary enrolled in an HMO with a risk contract. In such a situation, the unpaid hospital may turn to the beneficiary for reimbursement, thus abrogating the agreement between the HMO and the beneficiary that the HMO will pay for all in-plan services it orders.

It is not clear how willing PSROs will be to delegate review. The PSRO responsible for the review of patients enrolled in the Marshfield Medical Foundation (one of HCFA's demonstration sites) has thus far opposed Marshfield's requests for delegation. The Central Massachusetts PSRO which reviews the medical necessity of care provided to Fallon Medicare enrollees also opposes delegation to Fallon at this time. The circumstances here, however, raise a potential conflict of interest, since the membership of this particular PSRO comprises many of the same physicians who have formed an IPA known as the Central Massachusetts Health Care Foundation.[49] Also problematic is whether many HMOs will want PSRO review responsibility, since no provision has been made for the PSRO to reimburse the HMO for its services. HMOs may view this policy as inequitable, given that hospitals with delegated review functions are paid.

49. Lavin, J. H., "Doctor Surplus: Close-Up of a Town That's Feeling the Crunch," *Medical Economics*, September 29, 1980, pp. 69-80.

Medicare and Medicaid

The Medicare program relies on the internal quality assurance systems of the HMOs with which it contracts and the oversight responsibility of the OHMO. HCFA conducts no independent review of the quality assurance capability of the HMOs with Medicare contracts. On the other hand, the Medicaid program does require States contracting with HMOs to assume direct responsibility for quality of care. Regulation 42 CFR 431.513 requires the State agency to "establish a system of periodic medical audits to insure that the HMO provides quality and accessible care to enrolled recipients." The regulations further require that the State (1) conduct an audit at least annually at each HMO, (2) collect management data for medical audit personnel, and (3) ensure that the data include reasons for enrollment and termination and use of services.

One of HCFA's long-term policy objectives, to the fullest extent practical, has been to coordinate the operating procedures for the Medicare and Medicaid programs. Quality assurance requirements for Medicare and Medicaid HMO enrollees might be one area where a more uniform policy would be appropriate. Since nearly all Federal beneficaries are receiving is already prepaid health care are enrolled in qualified HMOs, the quality of care these beneficiaries are receiving is already subject to OHMO quality assurance, requirements. The Medicaid program, in effect, calls upon States to replicate the effort of OHMO. The quality assurance requirements of the Medicaid program may even be inhibiting the development of contracts between States and HMOs. States may be less inclined to pursue Medicaid contracts if they are required to set up new quality assurance programs. Similarly, HMOs already meeting OHMO quality assurance requirements may view one more set of standards and data requirements as not worth the cost and effort.

The PHRED Quality Assurance Demonstration

In addition to rate-setting and enrollment studies, the third major component of the PHRED project was to demonstrate and evaluate two alternative quality assurance strategies: an encounter data system (the monitor approach) and a selective data acquisition approach based on traditional medical audit review techniques. Both systems apply computerized criteria logic to age, sex, diagnosis, and service data and report the performance of the HMOs in passing or failing the criteria for the services examined. The first task in implementing the demonstration was to identify the criteria of performance to be applied to both information systems. Over a period of several months, a panel of 12 experts organized a set of 332 criteria grouped into 20 sections according to ICDA-8 diagnostic codes. The criteria set was reviewed by numerous local professional organizations and individuals. Three California HMOs with Medicaid contracts agreed to participate in the demonstration. The two data acquisition approaches each use a different subset of these 332 criteria.

PHRED project staff designed and implemented the monitor approach. In doing so, PHRED adapted the claims-based Physicians Ambulatory Care Evaluation

(PACE), which is an approved Medicaid Management Information System operated for the State of Utah by the Utah Professional Review Organization. The key characteristic of the monitor method is that it uses information on all patient encounters submitted by the HMO.

To operate the system, PHRED developed computer modules to collect and edit encounter and Medicaid eligibility data, to screen 250 criteria against the encounter data, and to generate potential exceptions to quality of care by the patient and/or provider. These systems can maintain and update patient profiles of care rendered and produce reports reflecting HMO and physician performance levels.

The selective approach was developed and tested by the Kaiser Research Center under contract with the State of California. The system uses a set of criteria programmed into a mini-computer. The program's branching logic instructs nurse abstractors to look for specific conditions in a patient's chart that will satisfy the question posed. The system reports "passes" and "failures" to the criteria and outlines performance rates for the criteria in each plan. Kaiser is preparing a report on the selective data acquisition system which will describe the history and results of the mini-computer application of 125 criteria derived from the PHRED criteria set.

As of December 1980, all data had been collected from the demonstration sites. SysteMetrics, Inc. is evaluating the two data acquisition systems to identify the preferred approach for California. The criteria against which the two systems are being evaluated include: cost, completeness, data validity, and acceptability to the HMOs.

The evaluation is scheduled to be completed in spring of 1981. Each system is expected to have benefits and drawbacks. The selective system is probably less expensive and easier to implement, since it requires no changes in HMO operations. Implementation of the monitor system would require more front-end costs as well as modifications to current HMO reporting systems. However, the information generated by the monitor system, once in place, could facilitate rate-setting and performance evaluation in areas outside of medical quality. California has accepted a budget proposal prepared by PHRED staff to implement the monitor system into the State agency's review activities.

Program Policy Considerations

Medicare

All available information indicates that Medicare enrollment will not accelerate appreciably unless major reforms in reimbursement are implemented. However, experience in implementing demonstration projects has highlighted the need for greater flexibility in the policies and procedures which HMOs will be required to follow in interacting with HCFA, intermediaries, carriers, providers, and beneficiaries under a full risk reimbursement process. These procedures, problems, and alternatives are discussed below.

Claims Processing

The current system for reimbursing HMOs under Medicare draws heavily on procedures developed for fee-for-service reimbursement. The major reason is that both cost and risk formulas authorized by Section 1876 involve reimbursement on the basis of the cost of services rendered. Neither method is prospective. Consequently, the administrative procedures currently in place are not always appropriate for reimbursement methods not tied to specific services rendered, as in the case of the demonstration projects.

An example is the set of procedures an HMO must follow in paying providers for Part A services. Under current Section 1876 risk contracting, an HMO may elect to pay all Part A claims except those for dialysis and related services. This option (referred to in the HMO Operating Instructions as "Option C") is the one selected by each of the demonstration projects. Each demonstration HMO is requesting the providers it deals with to submit claims on its own forms for processing by the HMO. However, under Section 1876 procedures, HMOs are also required to obtain the Medicare inpatient billing form (HCFA-1453) from each provider, and if payment is made for the service, to forward the bill to the appropriate intermediary for transmittal to Baltimore. A HCFA-1453 is required to permit updating of the beneficiary's master record with utilization information, so that individual spell of illness and lifetime benefit limitations can be tracked accurately. These utilization indicators become important if the beneficiary disenrolls from the HMO.

HMOs and providers have both objected to this procedure because it creates additional paperwork for providers, who must often prepare two billing forms, and introduces some chance for duplicate payment and administrative mix-ups. A more appropriate procedure may be to allow the HMO to require its own billing forms from in-area providers and not to dictate that HCFA-1453 forms also be submitted. Under this arrangement there would be no transmittal of HCFA-1453s to Baltimore or updating of the beneficiary's record as long as s/he was enrolled. A similar procedure could be followed for out-of-area provider claims, that is, they would not be returned to the intermediary for transmittal to Baltimore to update the beneficiary's record. In the majority of cases, the beneficiary would not be disadvantaged if his/her master record were "frozen." Rather, it would benefit many. It is probably not worth the administrative cost to track all these bills under a prepaid arrangement.

Another potential administrative problem is the handling of claims for out-of-plan services. Under claims processing Option C, these claims (for both Part A and Part B services) are processed and paid by the HMO. If a claim is sent by the provider or beneficiary directly to the intermediary (or carrier), the intermediary will receive a message in the query reply indicating that the beneficiary is enrolled in an Option C risk-basis HMO and that the claim should be sent to the appropriate HMO. The problem is that there is nothing to prevent the intermediary or carrier from actually making payments on such a claim, rather than

forwarding it to the HMO, as instructed. If the intermediary inappropriately makes payment for an out-of-plan service, there is no mechanism for withholding some reimbursement from the HMO for that service under a prepaid arrangement. In addition, if duplicate claims are sent to the intermediary and the HMO by the provider, duplicate payment could result for the same service.

Coverage of Non-Medicare Services

HMOs generally feel hampered by the restrictions imposed by the current Medicare benefit package. If an HMO believes it can provide the current services without imposing current restrictions, and still remain within its rate, it should be permitted to do so. For example, SNF services are normally covered only if the stay is preceeded by a three day covered hospital stay. The primary purpose for this requirement is to provide some guarantee that lower levels of care in SNFs are not covered under fee-for-service reimbursement. Under capitation reimbursement, however, such safeguards are not necessary, and it could be left up to the HMO to determine which stays require a covered level of care, regardless of prior hospital stay. All the demonstrations have requested a waiver of the three day requirement, and the waiver has been approved in each case. Additional examples could include coverage of physician extender services and provision of home services by nurses.

High and Low Option

Section 1876 requires that HMOs offer the basic Medicare benefit package to their Medicare enrollees and only offer additional benefits on an optional basis for a supplemental premium. The demonstration HMOs have requested waivers to permit them to offer one comprehensive package only, which includes benefits normally not covered by Medicare. The beneficiary pays for some of these extra services through his/her premium, and the remainder are covered through the capitation rate. The HMOs believe that the requirement to offer a "low option" is administratively burdensome. The basic Medicare benefit package is not consistent with normal HMO comprehensive benefits, and HMOs are not generally prepared to administer them. Beneficiary interest in low option plans appears very minimal based on the GHC experience and that of HMOs with cost contracts.

Premium for Low Option

Current regulations prohibit the HMO from charging a premium for low option which is higher than the actuarial equivalent of coinsurance and deductible. Under cost reimbursement, the premium is determined prospectively and subsequently adjusted to reflect actual utilization. For full risk reimbursement, the premium is not adjusted retrospectively. Often the prospective premium is considerably lower than the comparable premium charged by private insurers for similar benefits. HMOs argue that the premium should not be set to the actuarial equivalent, but to the rate required by the HMO to generate required revenues. A possible compromise is to require the HMO to inform the beneficiary of the actuarial equivalent of coinsurance and deductible, but to permit the HMO to charge a higher rate, as long as it is lower than the lowest private insurer rate.

Institutionalized Beneficiaries

An additional issue with some HMOs has been the requirement that hospitalized or institutionalized beneficiaries must be allowed to enroll. This is counter to some HMOs' policies. Because the AAPCC and the reimbursement rates can be adjusted appropriately, it may be advisable to allow HMOs not to enroll institutionalized beneficiaries if this is their practice with their non-Medicare enrollees. On the other hand, if HMOs wish to play a significant role in providing health care for an increasingly aged American population, long-range interests of both HMOs and beneficiaries may be better served by enrolling the institutionalized.

The issue of hospitalized beneficiaries is more complex, since it raises the question of favorable selection. HMOs argue that they should not be required to assume responsibility for a Medicare beneficiary in the middle of a hospital stay, since this can disrupt the current beneficiary-physician relationship. In the private sector, the HMO would not assume responsibility until the patient was discharged.

Renal Beneficiaries—Coinsurance and Deductible

Under each demonstration, a single enrollee premium is calculated based on the average actuarial equivalent value of deductible and coinsurance expenses, plus the value of non-Medicare covered benefits not covered by the capitation rate. All enrollees are charged the same rate, even though the capitation rate may differ for different age and sex groupings of enrollees. If renal beneficiaries are enrolled, as is the case with the Marshfield project, the renal enrollee will pay much less than the actuarial equivalent of renal-related deductible and coinsurance. (This fact could cause most renal beneficiaries in the area to enroll.) The result is that either the HMO or the other beneficiaries must subsidize this group. Otherwise renal enrollees would have to pay an extremely high premium. A similar problem arises even if the HMO does not enroll renal beneficiaries (as is the case with the other projects) because an aged or disabled beneficiary may develop renal disease.

Renal Beneficiaries—Master Record Annotation

HCFA master records of over-65 Medicare beneficiaries who develop end stage renal disease (ESRD) are often not annotated for several months after the beneficiary begins receiving routine dialysis. Thus, demonstrations such as Fallon, which are not at risk for renal beneficiaries, could face cash flow problems should a number of their enrollees develop permanent kidney failure. This is because cost reimbursement to the HMO for such enrollees can be initiated only after verifying that the beneficiary's master record is ESRD-annotated. Similarly, demonstrations such as Marshfield, for which separate rates have been calculated for

renal beneficiaries, would face perhaps months of waiting for record annotation to trigger the rate which incorporates the much higher renal costs. To address this problem in the demonstrations, the HCFA office which updates master records will receive special requests to annotate a beneficiary's record upon provision of documentation that a particular enrollee has permanent kidney failure. While this system should be adequate for the few HMOs in the demonstrations, it may not be feasible for an expanded number of HMO Medicare contracts.

Cost Reporting

Under current cost and risk arrangements, HMOs are reimbursed on the basis of cost, with a consequent need for them to prepare quarterly and annual cost reports. Under a capitation arrangement, cost reports are not necessary because they are not used in determining the next year's rates. Under the demonstrations, cost data will be collected for evaluation purposes only, and will fulfill no operational needs.

HMO Medicare Manual

The lack of a formal HMO manual has contributed to confusion on the part of intermediaries and HMOs. Intermediaries in particular have not demonstrated a knowledge of HMO claims processing and reimbursement procedures.

Medicare Cards

Several HMOs have expressed strong reservations about allowing beneficiaries to retain their regular Medicare cards, and would prefer to issue their own cards instead. These HMOs argue that a special card would curtail out-of-area usage by identifying a beneficiary as a lock-in HMO member to out-of-area providers. Out-of-area usage has been a serious problem for GHC, resulting in numerous administrative problems and dissatisfied beneficiaries. A special card would also serve as a reminder to beneficiaries of the lock-in provision. Problems with this possibility include the difficulty of persuading beneficiaries to relinquish their Medicare cards. (Even if they do, they can request that another card be issued.) Another problem is the current unfamiliarity on the part of many providers with anything except the normal Medicare card.

Medicaid

Administrative procedures have not been as serious an issue under Medicaid because of the relative flexibility of the States in administering their programs. Nonetheless, one problem which has been cited by a few HMOs currently holding Medicaid contracts is the impact of high disenrollment rates caused by loss of Medicaid eligibility. This increases the HMO's administrative cost and often forces the HMO to retroactively seek reimbursement from other sources for services rendered to enrollees who were later demonstrated to be ineligible for Medicaid benefits. This problem can be particularly acute in those instances where the State is slow to notify the HMO of loss of eligibility. Unfortunately, HCFA does not have data on numbers or rates of disenrollment due to loss of eligibility in various HMOs or various States, but HMOs have frequently cited this as a significant problem. Demonstrations are being initiated in California and Hawaii to test the concept of guaranteed six month eligibility for Medicaid recipients who enroll in an HMO. A demonstration is also planned in Massachusetts in which eligibility for dental services only will be guaranteed to recipients who voluntarily enroll with participating prepaid dental practices.

Knowledge Gaps

In the previous sections of this report, we have primarily addressed what has been learned thus far about Medicare and Medicaid experience with HMOs. Several important issues and questions remain, the answers to which should greatly facilitate growth of public sector contracting with HMOs. These issues are described below.

Medicare

What is the impact of full risk reimbursement? Many HMOs have claimed that if the Federal government would only pay them like the private employers, prospectively, with no adjustments based on actual costs, then more HMOs would contract to serve Medicare beneficiaries. However, these claims are made with little, if any, knowledge about the real impact of full risk reimbursement. While the Group Health Cooperative generated a remarkable savings in the first year of its Section 1876 risk contract, its means were controversial. GHC is an established HMO with its own hospital; other HMOs may not be able to replicate its savings. Moreover, the GHC savings have decreased over the years, so that its costs have risen from 78 to 90 percent of the AAPCC. Similarly, Fallon's second year adjusted community rate rose from 90 to 95 percent of the AAPCC. Although the HMOs participating in the capitation demonstrations do not constitute a representative sample of all HMOs, a relatively large number initially were not able to project large savings which could be turned into additional benefits. We will not have any more than anecdotal information about the impact of full risk reimbursement until the current demonstration projects have been evaluated, although we expect to report preliminary findings by mid-1982.

How can Medicare beneficiaries best be encouraged to enroll in HMOs without a richer benefit package than is currently covered under Title XVIII? The demonstrations thus far have shown that additional benefits and/or reduced premiums are a strong incentive for Medicare beneficiaries to join an HMO. This finding essentially corroborates the observations of researchers studying employed HMO members that economic benefits are the chief attraction to joining an HMO. This incentive is recognized in the proposal to return to beneficiaries the difference between 95 percent of the AAPCC and the adjusted community rate in the form of additional benefits or reduced premiums. However, what happens if an HMO with a Medicare contract cannot generate such a savings? Without the additional benefits/reduced premiums, it may be just as difficult to attract the Medicare beneficiary as it is under cost reimbursement. The problem may be especially

serious for young HMOs that have not yet maximized efficiency and for HMOs whose AAPCC is low due to possible under-utilization or access barriers in the fee-for-service system (for example, Marshfield). While the Medicaid beneficiary may be motivated to join an HMO to achieve better access to providers, this is not generally a problem for Medicare beneficiaries. To the contrary, one expects Medicare beneficiaries to be reluctant to sever access to already established doctor-patient relationships.

How many HMOs would be interested in a full risk reimbursement contract under Medicare? We do not know whether more than a handful of HMOs would enter into full risk contracts with HCFA, given the opportunity. However, it seems safe to hypothesize that, as in the private sector, if several HMOs can successfully demonstrate their viability under full risk, more would shortly follow.

Medicaid

What is the most effective means of motivating Medicaid recipients to enroll in HMOs? State of the art wisdom regarding alternative methods of stimulating Medicaid enrollment in HMOs offers the following marketing choices: (1) door-to-door, (2) mailings, (3) welfare office presentations, and (4) incentives such as cash payments and/or guaranteed eligibility combined with any of the preceding methods. The PHRED project's tentative findings argue in favor of welfare office presentations on the grounds that 16 percent penetration provides, across the board, sufficient enrollees to maintain viable health plan contracts. However, some HMOs will not be as well off if door-to-door solicitation is abolished, particularly those plans that were running aggressive door-to-door campaigns. On the other hand, PHRED claims that while those plans may suffer, other plans which previously did not contract because they did not want to market door-to-door will now sign contracts. Overall, HMO penetration will remain constant or increase. It will be important to look more closely at the impact on individual HMOs of abolishing door-to-door marketing, as well as to examine the analyses of the complete data set from Membership Studies, before positing firmer results. The value of offering guaranteed eligibility and cash payment as incentives to enrollment must be evaluated. A clear answer to this question awaits testing of incentives, as well as replication of the PHRED experience in other States.

Medicare and Medicaid

Do HMOs favorably select? The answer to this question has crucial significance to the future of HMOs and public payer participation. Proponents of both favorable and unfavorable selection have valid arguments. This is clearly an area where future research is warranted in both the Medicare and Medicaid programs.

If favorable selection occurs, is a health status factor important to incorporate into calculation of AAPCC? Given the complexity of devising a health status factor and collecting the data necessary to use it, policymakers must ask whether health status is sufficiently influential, in and of itself, to warrant inclusion in the AAPCC. It may be that the AAPCC factors currently used (age, sex, welfare, and institutional status) account for most of the effect of health status.

If health status should be included in the AAPCC, how? Currently, no existing or planned Medicare data base contains an acceptable health status measure. Until the controversy over measuring quality of care is resolved, it is unlikely that there will be agreement about the proper means of measuring health status.

Future Research

Based on the above questions, the future research and demonstration agenda is likely to comprise the following activities:

(1) Complete the current capitation demonstrations and evaluate them with particular emphasis on the selection issue, the impact of full risk reimbursement, and the effectiveness of alternative marketing strategies. In assessing whether selection occurred under the demonstrations, it will be necessary to develop an acceptable measure of health status which may later be incorporated into prospective calculation of the AAPCC.

(2) Conduct demonstrations to determine the impact of guaranteed eligibility and incentive cash payment on Medicaid enrollment.

(3) Compare utilization and cost experience of Medicare enrollees enrolled under cost and risk contracts. The results of such studies may shed some light on whether the claims of HMOs of greater efficiency under full risk as opposed to cost are valid.

(4) Implement new Medicare risk-sharing demonstrations with organizations which do not fully satisfy the HMO definition, but have the capability of achieving some of the efficiencies of HMOs.

(5) Conduct demonstration projects to test competition models and compare how HMOs perform to other organizations providing a comprehensive health service package.

Acknowledgments

The authors wish to express their appreciation to Barbara Cooper, Director, Office of Demonstrations and Evaluations, who provided many valuable comments on various drafts of this paper, and to Donna Eskow, who made suggestions which improved its style and literacy. Finally, we want to thank Lynn Betz and Iris Bridge, who flawlessly and uncomplainingly typed the many drafts of this report.

Appendix A: Descriptions of Medicare Capitation Demonstration Projects

Fallon Community Health Plan

The Fallon Community Health Plan is a qualified HMO jointly sponsored by the Fallon Clinic and Blue Cross of Massachusetts. As of September 1980, it served 30,000 members, including 200 AFDC beneficiaries, in the Worcester area. Fallon is a one-group staff model HMO employing over 50 staff physicians. By the end of its demonstration contract in December 1982, Fallon hopes to achieve a 15 percent penetration in its service area, yielding a total enrollment of 6,000 Medicare beneficiaries with Part A and B, as well as Medicaid Old Age Assistance recipients.

Marketing efforts to date have been targeted at group and non-group "Medex" subscribers, offering a dual choice between current coverage and that available through the Senior Plan. Senior Plan marketing efforts began on February 7, 1980, and within a month, the first year enrollment projection of 3,600 had been achieved. The marketing strategy focused on a "Health Fair" at the Fallon Clinic held prior to their enrollment campaign. The Health Fair offered presentations and talks about the plan, tours of the Fallon facilities, and booths dealing with a variety of topics generally related to the health and welfare of the elderly. Approximately 4,000 people attended. Fallon also held five open houses and ran newspaper ads. The ads contained a card for interested readers to send in to receive a brochure and application. Fallon received over 3,000 returned cards. In addition, Fallon obtained a mailing list of Medicare supplemental policyholders from Blue Cross of Massachusetts, which it used to disseminate literature in Worcester County.

Fallon's second open enrollment campaign began on September 15 and ended on January 10, 1981. The plan enrolled 1,700 new members during that period. About 23,000 non-group "Medex" subscribers received a brochure mailing, along with 900 people on a waiting list. Fallon held five open houses, placed newspaper ads, and made presentations to employer-retiree groups. Fallon decided not to hold a health fair based on its marginal benefits relative to costs.

Fallon's rates are based on an adjusted community rate (ACR). During the first year, its ACR was low enough, compared to area fee-for-service costs, to permit the coverage of several additional benefits at a $7.50 monthly premium while the plan was reimbursed at 90 percent of the Area Prevailing Cost. (The Area Prevailing Cost is the AAPCC where no adjustment is made for the demographic characteristics of HMO enrollees.) The additional benefits included: prescriptions with $1.00 copayment, eye examinations and one pair of eyeglasses, preventive services, and reduced coinsurance and deductible expenses. This generous benefit package probably explains the success of Fallon's enrollment efforts. Fallon offered beneficiaries the same benefit package at the same premium when new rates went into effect January 1981, even though the plan's reimbursement rate increased to 95 percent of the AAPCC.

Marshfield Medical Foundation

The Greater Marshfield Community Health Plan (GMCHP) is a non-Federally qualified HMO which was established in 1971. It is sponsored by the Marshfield Clinic (a 160-physician, multi-specialty, group practice), St. Joseph's Hospital, Blue Cross of Wisconsin, and Surgical Care Blue Shield. The plan services over 55,000 residents in rural central Wisconsin, incorporating all or parts of seven counties. The Marshfield Medical Foundation is the incorporated entity which was established by GMCHP to exclusively administer the plan's Federal programs.

Under the demonstration, GMCHP is being offered to 18,000 Medicare beneficiaries through a continuous open enrollment. GMCHP has developed special marketing methods and materials to accommodate the Medicare beneficiary. Numerous meetings of public and senior citizen organizations have been held, and a special enrollment office has been established at the clinic. The plan has also pursued educational activities aimed at Medicare beneficiaries. These efforts resulted in enrollment of approximately 6,000 Medicare beneficiaries between April and August 1980. Marshfield's second enrollment campaign increased total plan members to 7,436, of whom 143 have disenrolled (68 percent due to death). Marshfield's generally successful enrollment was expected, since the demonstration includes the major providers in the service area. Total enrollment was targeted at 12,000 by March 1981, but only 7,929 had enrolled by the end of February.

GMCHP benefits, which encompass and extend Medicare benefits and eliminate deductibles and copayments, are financed by a fixed prospective capitation payment from HCFA combined with an enrollee premium. The capitation rate has been derived from an actuarial adjustment of the GMCHP community rate which reflects the greater *per capita* utilization of services by the Medicare population. HCFA's capitation payment for the first contract period was set at 99 percent of the Area Prevailing Cost (APC) for non-chronic renal disease (CRD) beneficiaries and 98 percent for the second contract period, which began October 1, 1980. A special capitation rate for the CRD beneficiaries has been set at 95 percent of the CRD AAPCC for both the first and second contract period.

Kaiser-Portland

The Kaiser Permanente medical program is the largest non-governmental health care provider in the world. The program provides comprehensive care to over 3.6 million persons in seven geographic areas. Kaiser is conducting the Medicare demonstration in the Oregon region, which includes five counties and currently serves more than 220,000 persons, or about 20 percent of the population of the Portland-Vancouver metropolitan area. The Oregon region maintains two hospitals, several ambulatory care facilities, a mental health

center, and three dental facilities. Kaiser-Portland currently has a GPPP (Section 1833) Medicare contract under which 15,000 Medicare beneficiaries receive Part B services. There are approximately 309,000 Medicare beneficiaries in the region.

Kaiser's demonstration project with HCFA, which began in June 1980, has an enrollment of approximately 6,000 beneficiaries (4,500 new enrollees) in a comprehensive Medicare plan (M-Plan), which provides the entire Medicare benefit package as well as some benefits not covered or only partially covered under Medicare. Eligibility is limited to Medicare beneficiaries who have Parts A and B coverage, qualify for Medicare aged or disabled coverage, and live in the health plan service area. Enrollment is not offered to Medicare members who are institutionalized or who qualify for ESRD at the time of application, or to Medicare members who have Part B coverage only.

The M-Plan offers Medicare Parts A and B covered benefits without deductible or coinsurance limitations. The benefit package includes routine physical examinations, examinations for eyeglasses and most immunizations, full coverage for prescribed home health care, and outpatient mental health services (non-psychiatric). Under the demonstration, Medicare pays 95 percent of the AAPCC for the Portland metropolitan area, and the Kaiser rate of profit, as reflected in the Adjusted Community Rate, is limited to that for private enrollees. The difference between 95 percent of the AAPCC and the ACR, called savings, will be returned to the Medicare beneficiaries as a reduction in dues and/or as new services. During the first enrollment, enrollees were randomly assigned to two groups: one group was offered the special Medicare M-Plan program with no monthly dues. The second group was offered the M-Plan or a choice of the M-Plan plus three benefit options: (a) no dues; (b) eyeglasses, hearing aids, and drugs (with co-payment)—$6 dues; (c) dental care and dentures—$9.81 dues; and (d) eyeglasses, hearing aids, and dental care—$15.81 dues. Kaiser employed a variety of marketing approaches, including spot television advertising, to identify the most effective enrollment incentives.

InterStudy—A Medicare Multiple Choice Program for Minneapolis/St. Paul

InterStudy is acting as a broker for four HMOs that are testing a competitive market model for Medicare beneficiaries in the seven counties which compose the Minneapolis/St. Paul area. Beginning in May 1981, during open enrollment, each of the participating plans will offer a low option plan consisting of all Medicare A and B services, plus at least one additional service. In addition, all HMOs will offer a high option plan with a health screen. During open enrollment, all applicants who fail the health screen are offered the low option plan. During the remainder of the year, those individuals who fail the health screen are offered the opportunity to enroll during the next open enrollment period.

InterStudy is testing a "wise-buyer" public education effort to heighten awareness of the choice of plans. InterStudy will prepare educational material to provide information on the service package of each participating plan and discuss its advantages and disadvantages. Reimbursement rates are set at 95 percent of the AAPCC, based on the actuarial category into which each enrollee falls. A key hypothesis of the project is that competition among the plans for Medicare enrollees will cause each to offer as many additional benefits as is financially possible. During HCFA negotiations with the four HMOs, the following issues surfaced:

- The HMOs were very concerned that they would experience unfavorable selection during open enrollment. They believed that a fixed monthly premium would encourage unfavorable selection, particularly for IPA model HMOs.
- During the first year, the HMOs were very cautious about offering many additional benefits as part of the low option because they had no previous experience with the Medicare population.
- The HMOs believe they should be able to health screen during the remainder of the year to counterbalance the open enrollment requirement.

Health Central

Health Central is a Federally-qualified staff model HMO which initiated operations in January 1978. The HMO serves the Ingham-Eaton-Clinton county region of Michigan, which comprises Lansing and surrounding areas. Initially, Health Central anticipated non-Federal enrollment levels of 4,000, 10,000, and 18,000 in its first three years of operation. Enrollment far exceeded those projections and was frozen at approximately 22,000 in early 1979.

Health Central signed a cost reimbursement contract with HCFA in October 1978 for services to Medicare beneficiaries. However, only a handful of Medicare beneficiaries have been enrolled under this contract because Health Central's service capacity has been filled by the unexpectedly high enrollment levels described above. It is anticipated tnat the cost reimbursement contract will be replaced by the risk reimbursement contract when the second phase of the demonstration begins.

This demonstration project will involve both Medicare and Medicaid beneficiaries. All covered Medicare services will be furnished, as will all Medicaid-covered services with the exception of dental benefits. The plan will offer additional benefits to the standard benefit packages. Approximately 4,000 beneficiaries (2,200 Medicare and 2,200 Medicaid) are expected to be enrolled within the first two years of this part of the demonstration.

Phase I (the design) of the demonstration began in November 1978. During this phase, Health Central encountered serious financial problems which threatened its continuance. The financial difficulties were caused by excessively rapid enrollment, which resulted in a loss of management control over utilization. HCFA

suspended negotiations with Health Central on the demonstration during that period. Those problems have now been resolved, principally through the financial assistance of Blue Cross and Blue Shield of Michigan, which obtained control of the HMO in August 1979.

Most of 1980 was spent negotiating an acceptable reimbursement risk arrangement, recognizing Health Central's minimal financial reserves, as well as resolving flaws in the design protocol. Tentative agreement has been reached on the risk arrangement, and the design issues have been resolved. A May 1981 start-up of Phase II activities is now anticipated.

Kitsap Physicians Service

Kitsap Physicians Service (KPS) of Bremerton, Washington, is a non-Federally qualified HMO which was established in 1946. It is sponsored by all of the practicing physicians in the plan's service areas (three counties) and planned to offer Federal beneficiaries additional services and reduced cost-sharing incentives for enrollment. The plan currently services over 62,000 people. KPS originally planned to offer 10,000 Medicare beneficiaries a more comprehensive alternative to their existing coverage under Federal law. Under the risk contract, rates were to be based on an actuarial approach, with the final rate expected to be at or below 95 percent of the AAPCC.

Kitsap noted that hospital days in its area were already lower than the national average and believed that hospital costs were rising faster than would be recognized in a prospective APC. Since Kitsap wanted to pay its physicians higher than Medicare reasonable charges, but was unwilling to assume it could reduce hospital days, it was unable to achieve a rate lower than the APC. Kitsap requested a rate 15 percent more than the APC. HCFA therefore decided to terminate the demonstration.

Blue Shield of Massachusetts

The contract with Blue Shield of Massachusetts, to develop and establish a new HMO to be known as the Boston Community Health Plan, Inc. (BCHP), expired at the end of Phase I on September 14, 1980. The HMO proved infeasible due to the conflicting organizational priorities of the participants in the venture, as well as the inability of Blue Shield to accept a Medicare rate which would result in cost savings for HCFA and Medicare beneficiaries.

The Blue Shield proposal called for an HMO with a unique organizational network of providers: seven neighborhood health centers and the Primary Care Center of Boston City Hospital (BCH) to deliver ambulatory services, one or two other hospitals to offer acute care, and other selected specialists and facilities to provide the full range of Medicare and Medicaid benefits. It was hoped that the project could demonstrate a capitation and service delivery model that would serve as an alternative to the traditional, costly, urban delivery system and which might be replicated in other cities.

Enrollment would have been open to any resident of the city; however, the 370,000 persons living in the neighborhoods served by the health centers and BCH were targeted. Blue Shield initially planned for BCHP to enroll Medicare and Medicaid beneficiaries, near poor residents, municipal employees, Federal employees, and Blue Cross and Blue Shield subscribers. Marketing was to be handled primarily through door-to-door solicitation by neighborhood residents.

Blue Shield's chief reason for proposing the project was to demonstrate its corporate capability of holding an HMO license. The city of Boston, which was a subcontractor to Blue Shield, was primarily seeking a vehicle for reducing the financial burden of near poor residents receiving care at BCH and health centers. It eventually became apparent that Blue Shield believed it could not accept a rate set at or near 95 percent of the county area cost. Blue Shield argued that suburban Suffolk County costs were significantly lower than the actual costs of inner-city Boston. Because of the infeasibility of calculating a more sensitive area cost in the near future, HCFA suggested to Blue Shield that BCHP receive cost reimbursement for the demonstration's first year. In July, however, Blue Shield notified HCFA that it would take the State 12 to 14 months to review and approve an HMO license involving the complex relationship and beneficiary groups proposed for BCHP. This development, combined with all the other barriers which emerged during the course of Phase I, indicated that BCHP was not feasible.

Appendix B: Institutionalization Data for Determination of the AAPCC

The computation of the AAPCC requires the determination of the number of total Medicare beneficiaries and HMO enrollees who are institutionalized in the HMO's service area. Since the definition of "institution" is considerably broader than Medicare SNF, institutionalization data are not available from Medicare data sources. Three separate data sources were explored for the capitation demonstrations: (1) conducting a special survey; (2) obtaining the data from the State Medicaid agency; and (3) obtaining the data from national surveys.

The survey form which follows was established and mailed by HCFA's Office of Research, Demonstrations, and Statistics (ORDS) to all the institutions in the demonstrations' service area. The form requests the Medicare number of all beneficiaries residing in the institutions for over 30 days. The survey was used to collect institutional data for the Fallon and Marshfield projects. If an institution did not respond within 30 days, ORDS sent a follow-up letter the response rate from both survey was approximately 70 percent, with most large institutions responding. A review of the responses indicated that Medicaid numbers were

sometimes provided rather than Medicare numbers, and some institutions responded that they were no Medicare-certified and therefore received no Medicare reimbursement. Those facilities sending erroneous data were sent a follow-up letter. When the Medicare numbers were matched against the HCFA Master Beneficiary Records File for the HMO's service area, a large percentage of the numbers submitted did not match the numbers on the Master Beneficiary Record File. Approximately 30 percent (1,008 out of 3,280) and 22 percent (448 out of 2,240) of the data submitted for the Fallon and Marshfield projects, respectively, did not match.

The special survey appears to be the most reliable but time-consuming procedure to obtain data on institutional populations. There is clearly a problem with the reliability of the data submitted, but there is no obvious way to improve the accuracy of voluntarily-submitted information. It may not be practical if a large number of HMOs elect risk reimbursement in the future. It is also not clear whether institutions will continue to respond on an annual basis to survey requests.

The optimal procedure for obtaining accurate institutional data is to obtain the data directly from the State Medicaid program. This procedure was followed for the InterStudy and Kaiser demonstrations. Oregon was only able to provide statistics on all Medicare eligibles who were institutionalized, rather than those who were institutionalized for over 30 days. These data were acceptable to Kaiser, Portland. One limitation of this procedure is that the institutions included must be reimbursed by Medicaid. This may result in a more restricted set than was included in the survey. This problem is mitigated because the data on the HMO and service area institutional population were obtained from the same source.

Neither conducting a special survey nor requesting the institutional data from the State provides a simple and rapid procedure for collecting the required data. The third alternative that was explored, but not actually used for the demonstrations, is to collect the data from an existing survey. The following options were considered:

(1) In 1976, the Public Health Service (PHS) conducted the Master Facility Inventory, a survey of all institutions in the U.S. This survey provided a count of institutionalized persons by county, but not broken out by Medicare eligibility or age and sex. These can only be determined by extrapolation. The percentage of elderly on Medicare is known, so the Medicare institutionalized population can be approximated by using the national age-sex distribution obtained from another PHS survey, the National Nursing Home Survey. However, no comparable procedure could be established for the disabled population.

(2) In 1977, the Census Bureau conducted a Survey of Institutionalized Persons. This survey, which consisted of a national stratified sampling of institutions, provided an age-sex breakdown for the nation. We have obtained the percent of the total institutionalized population by age and sex from the Census Bureau on a State level. These percentages can be applied to data from the Master Facility Survey to obtain actual counts. The Bureau has indicated that "county estimates would be virtually useless and in some cases, impossible to produce (for example, in counties where no sample was taken)." As with the first option, assumptions must be made concerning the percentage of the aged who are Medicare eligible. We are unaware of any data that provide comparable estimates of the percentage of institutionalized individuals under 65 who are Medicare eligibles.

Although the above procedures require some extrapolation which may not be acceptable for actuarial purposes, they merit further exploration and refinement if the collection of institutional data is not to become excessively burdensome for HCFA. They could also be used to determine rough estimates of the AAPCC.

Form Approved
OMB No. 66-R1037

Survey of Medicare Institutionalized Beneficiaries

Institution Name _____

Address _____

_____

Person to Contact: _____

Telephone Number: _____

Type of Institution

_____Nursing Home

_____Convalescent Home

_____Rest Home

_____Sanitarium

_____Long Term Hospital

_____Other (Specify)

Please list the Name and Medicare Number of all Medicare beneficiaries who are now residing in your institution, and have resided there for at least 30 days.

	Name	Medicare Number
1.		
2.		
3.		
4.		
5.		
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10.		
11.		
12.		
13.		
14.		
15.		
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18.		
19.		
20.		

(Please attach additional sheets if necessary)

This report is authorized by Public Law 92-603. While you are not required to respond, your cooperation is needed to make the results of this study comprehensive, accurate, and timely.

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April 1981